

91 23501

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>ELIZABETH TURNBULL LOVE</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>31</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>4:45 PM</b>	
4. SOCIAL SECURITY NUMBER <b>212-38-5678</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-28-1898</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Lonaconing</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>10 Douglas Ave.</b>			
10f. ZIP CODE <b>21539</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>6</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>School Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Teacher</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert T. Love</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jennie Russell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Mamie Haugen</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 Douglas Ave, Lonaconing, Md. 21539</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Hill Cemetery 8-3-91</b>		20c. LOCATION — City or Town, State <b>Lonaconing, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration pneumonia</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <b>1 wk.</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Renal Failure; Congestive Heart Failure; gastrointestinal bleeding.</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D21458</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-1-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>74 Main St., Lonaconing, Md. 21539</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 06 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CAROLYN L. LUM</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 13, 1991</b>		3. TIME OF DEATH <b>3:30 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>218-74-5396</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>32</b> YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>April 17, 1959</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Boonsboro</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>8907 Lum Lane</b>				10f. ZIP CODE <b>21713</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 yrs.</b> College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Personal Residence</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Carroll John Robert Fraley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Louise Nazelrod</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Susan Hahn</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>606 East Patrick Street Frederick, Md. 21701</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery August 16, 1991 Hagerstown, Maryland</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Douglas A. Fiery</b>				22. NAME AND ADDRESS OF FACILITY <b>7606 Old National Pike Bast Funeral Home Boonsboro, Maryland</b>			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>MALIGNANT BRAIN TUMOR</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined		28. DATE OF INJURY (Month, Day, Year)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. DATE OF INJURY (Month, Day, Year)		29c. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		29d. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
29e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		29f. DESCRIBE HOW INJURY OCCURRED		29g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>John P. Carey, MD</b>		29c. LICENSE NUMBER <b>D19342</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8-13-91</b>				29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John P. Carey, MD 1190 MT Aetna Rd Hagerstown Md</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 15 '91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MABEL A. LOGUE</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>14</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1845</b> M	
4. SOCIAL SECURITY NUMBER <b>214-74-2189</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>March 30, 1899</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Baltimore County Gen. Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Reisterstown</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>211 Delight Rd.</b>		10f. ZIP CODE <b>21136</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaking</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Branford H. Owings</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ada Alice Nelson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William R. Logue</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>211 Delight Rd., Reisterstown, Md. 21136</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Deer Park Cemetery 8/17/91</b>		20c. LOCATION — City or Town, State <b>Smallwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>H. J. Eckhardt</b>		22. NAME AND ADDRESS OF FACILITY <b>Eckhardt Funeral Chapel 21117 11605 Reisterstown Rd., Owings Mills, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>CONGESTIVE CARDIOMYOPATHY</b> <b>ASCVD</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>COPD, ADM, S/P CARDIAC ARREST</b>					Approximate interval between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>C. Ravi</b>		29c. LICENSE NUMBER <b>D37333</b>		29d. DATE SIGNED (Month, Day, Year) <b>8.14.91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>C. RAVI MD, BCGH RANDALLSTOWN MD 21133</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 16 91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>JOSEPH M. MURPHY</b>				2. DATE OF DEATH MONTH <b>August</b> DAY <b>15</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1030</b> M	
4. SOCIAL SECURITY NUMBER <b>154-01-3566</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 11, 1906</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
RESIDENCE OF DECEASED							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Pocomoke</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>101 By Pass Road</b>				10f. ZIP CODE <b>21851</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>---</b>		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Postal Employee</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Patrick Joseph Murphy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine Walsh</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lena Murphy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2101 By Pass Road, Pocomoke, Md. 21851</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>First Baptist Cem.</b>		20c. LOCATION — City or Town, State <b>Pocomoke, Md.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Scott S. Melson</b>				22. NAME AND ADDRESS OF FACILITY <b>MELSON FUNERAL HOME P. O. Box 64, Pocomoke, Md. 21851</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Failure</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <b>Congestive Heart Failure</b>  <b>Advanced Coronary Artery Disease</b> </div> <div style="width: 30%;"> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF): </div> <div style="width: 30%; border-left: 1px solid black; padding-left: 5px;"> Approximate Interval Between Onset and Death </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis</b> <b>Transitional Cell Carcinoma of the urinary</b> <b>Renal Tumor; Bladder</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27a. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY		27c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		27d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Walter M. Baldred, M.D.</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>547 F Riverside Dr., Salisbury, MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BARBARA ELLA MULLIGAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 4 1991</b>		3. TIME OF DEATH <b>2:40 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-14-6841</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-19-1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Cumberland,</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>720 Kent Avenue</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Pharmacy</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Eugene T. Carney</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pearl Rosenmarkle</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Eugene H. Mulligan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>720 Kent Avenue Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.) <b>SS Peter Paul Cemetery 8-6</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jones &amp; Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Rupture of Aortic Arch Aneurysm</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Hypertension</b> b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe dilated ischemic cardiomyopathy Diabetes mellitus</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D 28184</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. B.S. MAHAL/909-B SETON DRIVE/CUMBERLAND, MD. 21502</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





REG. NO.

DHMH-16 Rev 1/89

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>James H. MURRAY</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>8</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1900</b> M	
4. SOCIAL SECURITY NUMBER <b>215-28-8105</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/3/29</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Gen</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		8c. COUNTY OF DEATH <b>AA</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Harwood</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1101 Cumberstone Road</b>				10f. ZIP CODE <b>20776</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korea</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Radar Research &amp; Design</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Westinghouse Corp. Electrical Engineer</b>			
17. FATHER'S NAME (First, Middle, Last) <b>E. Churchill Murray</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marjorie Burwell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alice H. Murray</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1101 Cumberstone Road, Harwood, MD 20776</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 8/10 Alexandria, VA</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeffrey S. Taylor</i>				22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cardiac Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		28. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Jones, MD Deputy</i>				29c. LICENSE NUMBER <b>D 06004</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William P. Jones, MD. PO Box 99 20711</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE COUNTY DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY C. MALAMPHY</b>						2. DATE OF DEATH MONTH <b>08</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:05 AM</b>	
4. SOCIAL SECURITY NUMBER <b>214-07-6534</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01-12-12</b>		8. BIRTHPLACE (State or Foreign Country) <b>Shaft, MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>A.A. COUNTY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Gambrills</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1997 Dairy Farm Road</b>				10f. ZIP CODE <b>21054</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Registered Nurse</b>			16b. KIND OF BUSINESS/INDUSTRY <b>State of Maryland</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Thomas F. Winters</b>						16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine Tippen</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John W. Malamphy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>500 Duvall Lane, Annapolis, MD 21403</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lakeview Memorial Park</b>				20c. LOCATION — City or Town, State <b>Sykesville, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia A. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 851 Annapolis Road, Gambrills, MD</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Heart Disease</b>									
DUE TO (OR AS A CONSEQUENCE OF):									
b. <b>Arteriosclerotic occlusive carotid &amp; peripheral arterial disease</b>									
DUE TO (OR AS A CONSEQUENCE OF):									
c. <b>more than 2 years</b>									
DUE TO (OR AS A CONSEQUENCE OF):									
d. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER <b>024756</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-13-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TSU-CHUN LIN, M.D./377-B GAMBRILLS ROAD/GAMBRILLS, MARYLAND 21054</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 15 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

TO THE REGISTRAR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTEANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEM:18 per FH  
G-679 9/6/91 cm

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 23509

1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARET S. MILLER</b>		2. DATE OF DEATH MONTH DAY YEAR <b>Aug. 12, 1991</b>		3. TIME OF DEATH M <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>220-46-1705</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 21, 1910</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington D.C.</b>		9. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3203 River Crescent Drive</b>		10f. ZIP CODE <b>21401</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>		17. FATHER'S NAME (First, Middle, Last) <b>Allen M. Sumner</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY RANDOLPH MORRIS</b>		19a. INFORMANT'S NAME (Type/Print) <b>Burton F. Miller</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3203 River Crescent Drive, Annapolis, MD 21401</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Monticello Asso. Graveyard Charlottesville, VA</b>		20c. LOCATION — City or Town, State <b>Charlottesville, VA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Clark E. Quinger</i>		22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic Cancer of the Lung</b> <b>Due to (or as a consequence of):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. <b>Due to (or as a consequence of):</b> c. <b>Due to (or as a consequence of):</b> d. <b>Approximate Interval Between Onset and Death</b> <b>6 mos</b>	
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>28b. TIME OF INJURY</b> <b>28c. INJURY AT WORK?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>28d. DESCRIBE HOW INJURY OCCURRED</b> <b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter F. Verkouw MD</i>		29c. LICENSE NUMBER <b>011653</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8/13/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Peter F. VERKOUW MD 1833 Forest Dr Annapolis MD 21401</b>		31. DATE FILED (Month, Day, Year) <b>AUG 16 1991</b>	



91 23510

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>George F. Mahoney Jr</b>		2. DATE OF DEATH MONTH <b>08</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1350 p.m.</b>
4. SOCIAL SECURITY NUMBER <b>578-40-2793</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>78</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>07/15/13</b>	8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>A.A.</b>
RESIDENCE OF DECEDENT				
10a. STATE <b>MD</b>	10b. COUNTY <b>AA</b>	10c. CITY, TOWN OR LOCATION <b>Annapolis</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>2207 River Crescent</b>		10f. ZIP CODE <b>21401</b>	10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W W II</b>	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Agency for International Development</b>		16b. KIND OF BUSINESS/INDUSTRY <b>State Department</b>
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE F. MAHONEY</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JONES</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Margot Mahoney</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1014 N. Royal St., Alexandria, VA 22314</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Quantico Veterans Cemetery Quantico, VA</b>		20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles E. Aringer</i>		22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiopulmonary arrest</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Renal failure</b>				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jack Lichtenstein</i>		29c. LICENSE NUMBER <b>D08194</b>	29d. DATE SIGNED (Month, Day, Year) <b>8-14-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jack Lichtenstein, M.D. 207 Ridgely Ave., Annapolis, MD 21401</b>				
31. DATE FILED (Month, Day, Year) <b>AUG 16 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Russell Leroy MICHAEL</b>				2. DATE OF DEATH MONTH <b>August</b> DAY <b>17</b> , YEAR <b>1991</b>		3. TIME OF DEATH <b>12:05 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-10-2781</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 29, 1907</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Homewood Retirement Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Frederick</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>31 West Patrick Street</b>				10f. ZIP CODE <b>21701</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accountant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Potomac Edison Company</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Roy C. Michael</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Etta Lease</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Anne M. Meilleur</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>326 Park Avenue, Frederick, Md. 21701</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery 8-20-91</b>		20c. LOCATION — City or Town, State <b>Frederick, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Allan H. Ruby M00703</b>				22. NAME AND ADDRESS OF FACILITY <b>Keeney &amp; Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular accident</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>W. J. Riddick M.D.</b>				29c. LICENSE NUMBER <b>D-12482</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/19/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Willis J. Riddick, M.D., Parkview Medical Center, Frederick, Md. 21701</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 19 1991</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DATE RECEIVED FROM IC.

11. 3. 2000

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*Journal of Management Education* 30(6)

1998 • Journal of Neuroscience • 18(18):7001–7011

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TO: Mr. J. Edgar Hoover, Director, FBI

91 23512

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PAULINE C MESSORIS</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>15</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>078-36-0075</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 31, 1905</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9. COUNTY OF DEATH <b>A.A. COUNTY</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>A.A. COUNTY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>99 Rippling Ridge Rd.</b>				10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Paul Laurie</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pauline Gulf</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joseph Messoris</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>99 Rippling Ridge Rd., Glen Burnie, Maryland 21061</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crestlawn Memorial Gardens 8/19</b>		20c. LOCATION — City or Town, State <b>Marriottesville Howard, MD</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY <b>Kirkley Funeral Home</b> <b>421 Crain Hwy., S.E. Glen Burnie, Maryland 21061</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>stroke</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>hypertension</b> b. c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>8/15/91</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER <b>036900</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print) <b>KRISHAN K. SINGAL, M.D./1600 CRAIN HIGHWAY, SW #201/GLEN BURNIE, MARYLAND 21061</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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Mr. [illegible] [illegible] [illegible]

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Arletta J. Mason</i>				2. DATE OF DEATH MONTH: 8 DAY: 14 YEAR: 91				3. TIME OF DEATH 2:52 AM	
4. SOCIAL SECURITY NUMBER 236-36-0168		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 04 06 26		8. BIRTHPLACE (State or Foreign Country) W. VIRGINIA	
9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH -	
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION ODENTON				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 508 STONEY HILL COURT				10f. ZIP CODE 21113		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BEAUTICIAN				16b. KIND OF BUSINESS/INDUSTRY HAIRDRESSING	
17. FATHER'S NAME (First, Middle, Last) H. MILTON LILLY				18. MOTHER'S NAME (First, Middle, Maiden Surname) STELLA R. LILLY					
19a. INFORMANT'S NAME (Type/Print) JO ANN BROOKS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1077 DICUS MILL ROAD-MILLERSVILLE, MD. 21108					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. JAMES CHURCH CEMETERY		DATE 8/17		20c. LOCATION — City or Town, State LOTHIAN, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME. 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.					
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Arrest</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <i>White Suppurative Infection</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>Intestinal Perforation</i> c. DUE TO (OR AS A CONSEQUENCE OF): <i>Hypertension</i> d. <i>Hypertension</i>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Beed A. Winkler</i>				29c. LICENSE NUMBER D30408	
29d. DATE SIGNED (Month, Day, Year) 8/14/91				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Beed A. Winkler 2600 Filing Heights Ave					
31. DATE FILED (Month, Day, Year) AUG 16 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Lester M. Mose Sr.				2. DATE OF DEATH MONTH DAY YEAR Aug. 13, 1991		3. TIME OF DEATH 5:00A M	
4. SOCIAL SECURITY NUMBER 236-03-0897		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 95 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-6-1895	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 22 Young Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Boonsboro	
9c. COUNTY OF DEATH Washington				10a. STATE Maryland		10b. COUNTY Washington	
10c. CITY, TOWN OR LOCATION Boonsboro				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 22 Young Avenue	
10f. ZIP CODE 21713				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War I				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 yrs. College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance Supervisor		16b. KIND OF BUSINESS/INDUSTRY Limestone Company	
17. FATHER'S NAME (First, Middle, Last) Jerome				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Mae BENNER			
19a. INFORMANT'S NAME (Type/Print) Robert L. Mose				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Young Avenue Boonsboro, Maryland 21713			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mountain View Cemetery		20c. LOCATION — City or Town, State Sharpsburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Douglas A. Fiery				22. NAME AND ADDRESS OF FACILITY 7606 Old National Pike Bast Funeral Home Boonsboro, Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): years Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Howard N. Weeks, M.D.				29c. LICENSE NUMBER D11255		29d. DATE SIGNED (Month, Day, Year) 8/14/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard N. Weeks, M.D., 580 Northern Ave., Hagerstown, Md. 21742							
31. DATE FILED (Month, Day, Year) AUG 15 '91				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23515

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Guy Emory Miller, Jr.				2. DATE OF DEATH MONTH 8 DAY 16 YEAR 91		3. TIME OF DEATH 0824 AM	
4. SOCIAL SECURITY NUMBER 220-01-4530		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 17, 1920	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Frederick				10a. STATE Maryland		10b. COUNTY Carroll	
10c. CITY, TOWN OR LOCATION Mt. Airy				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 2595 Gillis Road	
10f. ZIP CODE 21771				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 yrs. College (1-4 or 5+) None				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) P B X Installer		16b. KIND OF BUSINESS/INDUSTRY C & P Telephone Company	
17. FATHER'S NAME (First, Middle, Last) Guy E. Miller, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Humphrey			
19a. INFORMANT'S NAME (Type/Print) Beatrice G. Miller				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2595 Gillis Road Mt. Airy, Maryland 21771			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of facility, crematory or other place) Fairview Memorial Park 8/19/91		20c. LOCATION — City or Town, State Eldersburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles B. Miller, Jr.</i>				22. NAME AND ADDRESS OF FACILITY Burrier Funeral Home Winfield, Maryland 21784			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiovascular arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Cancer of the pancreas</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Myelodysplasia</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arthur B. Hamilton</i>				29c. LICENSE NUMBER D-18191		29d. DATE SIGNED (Month, Day, Year) 8-16-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Harold G. Manno, 40 187 Roman John D. Frederick MD 21702</i>							
31. DATE FILED (Month, Day, Year) AUG 19 '91				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. *[Handwritten signature]*



91 23516

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Virgie Althea POLING				2. DATE OF DEATH MONTH DAY YEAR August 12, 1991		3. TIME OF DEATH 1115 A M	
4. SOCIAL SECURITY NUMBER 236-64-7966		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr. 14, 1901	
8. BIRTHPLACE (State or Foreign Country) West Virginia				9a. CITY, TOWN OR LOCATION OF DEATH Oakland		9c. COUNTY OF DEATH Garrett	
9b. FACILITY NAME (If not institution, give street and number) Dennett Road Manor Nursing Home				RESIDENCE OF DECEDENT			
10a. STATE WV		10b. COUNTY Grant		10c. CITY, TOWN OR LOCATION Bayard		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. Box 3				10f. ZIP CODE 26707		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook		16b. KIND OF BUSINESS/INDUSTRY Restaurant	
17. FATHER'S NAME (First, Middle, Last) Sanford J. Knotts				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma ----- Rinker			
19a. INFORMANT'S NAME (Type/Print) Ruth R. Foster				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 657, Moorefield, West Virginia 26836			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bayard Cemetery		DATE 8/15/91		20c. LOCATION — City or Town, State Bayard, West VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bridget H. Stewart				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): b. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 week years — —
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Failure aphasia and Right Hemiplegia due to old stroke							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Walter K. Naumann MD				29c. LICENSE NUMBER D 25759		29d. DATE SIGNED (Month, Day, Year) 08-12-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Walter K. Naumann MD Accident MD 21520							
31. DATE FILED (Month, Day, Year) AUG 16 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 7 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elwood Ford Patrick				2. DATE OF DEATH 7 MONTH 31 DAY 91 YEAR		3. TIME OF DEATH 11:00P M	
4. SOCIAL SECURITY NUMBER 368-05-6909		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7 7 17	
8. BIRTHPLACE (State or Foreign Country) Michigan		9a. FACILITY NAME (If not institution, give street and number) Frostburg Com. Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frostburg		9c. COUNTY OF DEATH Allegany	
RESIDENCE OF DECEDENT							
10a. STATE Va.		10b. COUNTY Alexandria		10c. CITY, TOWN OR LOCATION Alexandria		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2420 Stirrup Lane				10f. ZIP CODE 22306		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Ret. Mechanic		16b. KIND OF BUSINESS/INDUSTRY Auto	
17. FATHER'S NAME (First, Middle, Last) Ray Patrick				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Mabree			
19a. INFORMANT'S NAME (Type/Print) Samuel K. Ryals				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2420 Stirrup Lane, Alexandria, Va. 22306			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Maple Grove Cemetery		20c. LOCATION — City or Town, State North Branch, Michigan			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral vascular accident							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> QOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  Dpty Med. Ex		29c. LICENSE NUMBER D 09157		29d. DATE SIGNED (Month, Day, Year) 8/1/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Snow, M.D. Dpty Med Ex 124 W 3rd St Cumberland Md 21502							
31. DATE FILED (Month, Day, Year) AUG 06 1991		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARIE A. PARRY</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:04 PM</b>	
4. SOCIAL SECURITY NUMBER <b>214-52-1561</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06 08 47</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>A.A. COUNTY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7978 CASTLE HEDGE DELL</b>				10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life (Do not specify dates).) <b>CUSTOMER SERVICE REPRESENTATIVE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>GRAPHIC SALES</b>			
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>EDWIN V. PARRY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7978 CASTLE HEDGE DELL-GLEN BURNIE, MD. 21061</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METRO CREMATORY, INC. 8/12</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Adult Respiratory Distress Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Cardiac Dysrhythmias - Tachycardia; Asystole</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Multi-System Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>(Post-Traumatic) - Brachogenic Carcinoma, Right</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. <b>PERITONITIS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>N/A</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frank A. Faraino, MD</i>				29c. LICENSE NUMBER <b>D02312</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. FRANK A. FARAINO, M.D./3001 S. HANOVER ST./BALTIMORE, MD. 21230</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Earl Frank POOLE</b>				2. DATE OF DEATH MONTH <b>Aug</b> DAY <b>17</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>8:55 A</b>	
4. SOCIAL SECURITY NUMBER <b>214-10-4837</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 16, 1906</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Frederick Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>	
9c. COUNTY OF DEATH <b>Frederick</b>				RESIDENCE OF DECEDENT			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Braddock Heights</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6652 Jefferson Blvd.</b>				10f. ZIP CODE <b>21714</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Automobile Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Automobile dealership</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry C. Poole</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Etta May Reeker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Patricia Mason</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8305 Boonsboro Pike, Boonsboro, Md. 21713</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mount Olivet Cemetery 8-21-91</b>		DATE <b>Frederick, Maryland</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert C. C. Basford</i> <b>M00021</b>		22. NAME AND ADDRESS OF FACILITY <b>Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASPIRATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>CEREBROVASCULAR ACCIDENT</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>13 Hrs.</b> <b>16 Days</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PARKINSON'S DISEASE</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James L. Roessler MD</i>				29c. LICENSE NUMBER <b>D20488</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES L ROESSLER MD PO Box 17 MIDDLETOWN, MD. 21769</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 19 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>LOUIS ELTON PADGETT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 14, 1991</b>		3. TIME OF DEATH <b>8:35 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-14-7028</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-23-1921</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>10505 CEDARVILLE ROAD, 8-2</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BRANDYWINE</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>PRINCE GEORGE'S</b>		10c. CITY, TOWN OR LOCATION <b>BRANDYWINE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10505 CEDARVILLE ROAD, 8-2</b>				10f. ZIP CODE <b>20613</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW2 1942-1945</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9TH GRADE</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OWNER, RESTAURANT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RETAIL FOOD SERVICE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HARVEY ELTON PADGETT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARTHA CAROLINE BURCH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LOUISE N. PADGETT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10505 CEDARVILLE ROAD, 8-2, BRANDYWINE, MD 20613</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MARYLAND VETERANS CEMETERY</b>		20c. LOCATION — City or Town, State <b>CHELTENHAM, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael K. Blankenship</i> <b>MICHAEL K. BLANKENSHIP, MO0857</b>				22. NAME AND ADDRESS OF FACILITY <b>THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Prostate Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kolutha Damm</i> M.D.				29c. LICENSE NUMBER <b>D 40479</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>AUG 20 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

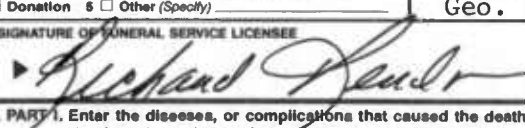

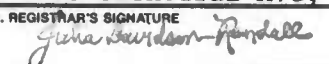
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Boris Pross</b>				2. DATE OF DEATH MONTH <b>Aug</b> DAY <b>23</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>6:30 P</b> M	
4. SOCIAL SECURITY NUMBER <b>094-24-6246</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr 11 1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Russia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Bethesda Retirement Nursing Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Chevy Chase</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Montgomery</b>				10c. CITY, TOWN OR LOCATION <b>Kensington</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>10225 Kensington Parkway</b>			
10f. ZIP CODE <b>20895</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Cauc.</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Civil Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Allied Chemicals</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Sargey Pross</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Unk.</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Irene Pross</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10225 Kensington Pkwy. Kensington, MD 20895</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Geo. Washington Med. School</b>		20c. LOCATION — City or Town, State <b>Washington, D.C.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Columbia Mortuary Services, Inc. 225 Missouri Ave. NW Wash., D.C. 20011</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiac arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Lila McConnell, M.D.</b>				29c. LICENSE NUMBER <b>D39456</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 24, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Lila McConnell, M.D. 4200 Cathedral Ave. NW #511, Washington, D.C. 20016</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 '91</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Gary Reed Phillips</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 15 1991</b>		3. TIME OF DEATH <b>7:40 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-50-9261</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>43</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01-10-48</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>141 Bond Street Apt. F</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>	
9c. COUNTY OF DEATH <b>Carroll</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>	
10c. CITY, TOWN OR LOCATION <b>Westminster</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>141F Bond Street</b>	
10f. ZIP CODE <b>21157</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Vietnam</b>				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5 +)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Forklift Operator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Printing</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Calvin Leroy Phillips</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Barbara Lee Brubaker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary A. Phillips</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>145 Bond Street, Westminster, MD 21157</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Westminster Cemetery 8/18 Westminster, MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Swann Liberty Myers</i>				22. NAME AND ADDRESS OF FACILITY <b>Myers Funeral Home 91 Willis Street, Westminster, MD 21157</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic cardiovascular disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Raymond D. Kobon</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 15 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARION D. KOBON 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 19 '91</b>				32. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>VENA E. Riley</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 4 1991</b>		3. TIME OF DEATH <b>1025 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-74-1575</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08-28-1896</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Cumberland Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cresaptown</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Route 6 Box 380</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>housewife</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert F. Winters</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Druscilla (Buskirk)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. William F. Riley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 6, Box 380 Cresaptown, MD 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Memorial Park</b>		20c. LOCATION — City or Town, State <b>8-7-91 Cumberland, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jon F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ca breast metastasis</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Peter J. Palmer MD</b>				29c. LICENSE NUMBER <b>D04981</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>P. HALLOS 302 SCHLEY ST. CUMBERLAND, MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 07 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>CHARLES CLINTON RINGER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 4, 1991</b>		3. TIME OF DEATH <b>9:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>170 30 0493</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>97</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-16-1893</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>	
9c. COUNTY OF DEATH <b>ALLEGANY</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Garrett</b>	
10c. CITY, TOWN OR LOCATION <b>Grantsville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Route 1, Box 135</b>	
10f. ZIP CODE <b>21536</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>College</b>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farmer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Farming</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Ringer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Caroline Wilttrout</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Doris Stein</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1, Box 135, Grantsville, MD 21536</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Grantsville Cemetery 8/6</b>		20c. LOCATION — City or Town, State <b>Grantsville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Newman Funeral Homes, P.A. 155 Main St., Grantsville, MD 21536</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>SEPTICEMIA</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>INTRABDOMINAL INFECTION</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE LUNG DISEASE</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide 4 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D25638</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. SATURNINA CHANG, M.D., FROSTBURG PLAZA, FROSTBURG, MD 21532</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 08 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23525

1. DECEDENT'S NAME (First, Middle, Last) <b>Lawrence E. Reed</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:51AM</b> M	
4. SOCIAL SECURITY NUMBER <b>213-24-5561</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>63</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>3/9/28</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland,</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>441 Walnut Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 8+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>retired</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Factory Worker</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Reed</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Olive Penner Reed</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Dewey Phillips</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>441 Walnut Street Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Restlawn Memorial Gardens 8-10</b>		20c. LOCATION — City or Town, State <b>LaVale, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James J. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Arteriosclerotic heart disease</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Diabetes</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dpty Med ex</b>				29c. LICENSE NUMBER <b>D 09157</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul Snow, M.D. 124 W 3rd St Cumberland Md 21502</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 08 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>CLYDE STEWART RUNION</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 7, 1991</b>		3. TIME OF DEATH <b>1:50 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214 05 7181</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC. 30, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WEST VIRGINIA</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9b. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>CUMBERLAND</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>912 FOREST EDGE DRIVE</b>		10f. ZIP CODE <b>21502</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HEAVY EQUIP. OPERATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CONSTRUCTION</b>	
17. FATHER'S NAME (First, Middle, Last) <b>EMORY RUNION</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>THERESA ASH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY MARGARET RUNION</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>912 FOREST EDGE DR. - CUMBERLAND, MD 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>RESTLAWN MEML. GARDENS 8/10/91</b>		20c. LOCATION — City or Town, State <b>LAVALE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stacy N. Zupchuck</i>				22. NAME AND ADDRESS OF FACILITY <b>GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cerebrovascular Accident</b>							
Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>Arteriosclerosis</b>							
c. <b></b>							
d. <b></b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Gout, Angina</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b></b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b></b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b></b>	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Welik</i>				29c. LICENSE NUMBER <b>D31875</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/08/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. - ROBERT WELIK, M.D., 921 SETON DRIVE, CUMBERLAND, MD 21502</b>							
31. DATE SIGNED (Month, Day, Year) <b>AUG 09 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CATHERINE E. RHOE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 7, 1991</b>		3. TIME OF DEATH <b>10:20 PM</b>	
4. SOCIAL SECURITY NUMBER <b>220162573</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-06-1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland,</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>19 Wempe Drive</b>			
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Register Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private Duty Nursing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph H. Griffin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lilly (Teal)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr Gordon B. Griffin</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Cumberland, MD 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Marys Cemetery</b>		20c. LOCATION — City or Town, State <b>8-12 Cumberland, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cholangiocarcinoma</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <b>CHF</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pneumonia</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D36766</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUGUST 8, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. VIC POONAI, M.D., 955 FREDERICK STREET, CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 09 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 7 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM B. REIO</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>08:55 AM</b>	
4. SOCIAL SECURITY NUMBER <b>577-26-6758</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05 30 03</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>A.A. COUNTY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>MILLERSVILLE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1082 DICUS MILL ROAD</b>				10f. ZIP CODE <b>21108</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SHARECROPPER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>TOBACCO FARMING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH REIO</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNIE THOMPSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>EARL J. DRURY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1082 DICUS MILL ROAD-MILLERSVILLE, MD. 21108</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METRO CREMATORY, INC. 8/12</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.</b>			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPTICEMIA</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimers</b> <b>asevd</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>N/A</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregorio, M.D.</i>				29c. LICENSE NUMBER <b>12-19524</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ELMO M. GAYOSO, M.D./273 - F PENINSULA FARM ROAD/ARNOLD, MARYLAND 21012</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodette</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23529

1. DECEDENT'S NAME (First, Middle, Last) <b>HARRY (NMN) ROBINSON</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH <b>21:25</b> M					
4. SOCIAL SECURITY NUMBER <b>233-40-9379</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 20, 1919</b>		8. BIRTHPLACE (State or Foreign Country) <b>Hagerstown, MD.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>WASHINGTON COUNTY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>HAGERSTOWN</b>				9c. COUNTY OF DEATH <b>WASHINGTON</b>			
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>WASHINGTON</b>		10c. CITY, TOWN OR LOCATION <b>HAGERSTOWN</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>402 SHERWOOD DRIVE</b>				10f. ZIP CODE <b>21742</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>WW #2</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>X</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>KNOUSE FOOD CHAMBERSBURG, PA.</b>		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>JOHN HENRY ROBINSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY ESTHER REBECK</b>							
19a. INFORMANT'S NAME (Type/Print) <b>CHATERINE WOLFORD</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>420 SHERWOOD DRIVE HAGERSTOWN, MD. 21742</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Paul's Church Cemetery</b>		20c. LOCATION — City or Town, State <b>Clearspring, MD.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Andrew K. Coffman</b>				22. NAME AND ADDRESS OF FACILITY <b>Andrew K. Coffman Funeral Home, Inc. 40 E. Antietam Street, Hagerstown, MD. 21740</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic Heart Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Dilated Cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>								Approximate Interval Between Onset and Death <b>1 yr</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b> <b>Chronic Obstructive Pulmonary Disease</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John H. Hornbaker, Jr.</b>				29c. LICENSE NUMBER <b>D077FS</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-14-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John H. Hornbaker, Jr 354 Mill St. Hagerstown, MD 21740</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

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91 23530

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Betty L. REEDER</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>18</b> YEAR <b>91</b>				3. TIME OF DEATH <b>6 25 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>200-30-9386</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/19/34</b>		8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number) <b>University of Md. Hoapital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>WASHINGTON</b>		10c. CITY, TOWN OR LOCATION <b>HAGERSTOWN</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>116 High St</b>				10f. ZIP CODE <b>21740</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Slasper Norman Thomas</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Florida Alice Brown</b>					
19a. INFORMANT'S NAME (Type/Print) <b>John R. Reeder</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>116 High St., Hagerstown, Md. 21740</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Boonsboro Cemetery</b>		DATE <b>8/18/91</b>		20c. LOCATION — City or Town, State <b>Boonsboro, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John H. Bast, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>BAST FUNERAL HOME, 7606 Old National Pike, Boonsboro, Maryland 21713</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> <b>PUD</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death <b>2 mos</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Wm. B. Miller MD</b>							
29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/18/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Univ of MD Medical Center</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 21 '91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research.

2. The second part of the report is a detailed description of the methods used in the study. It includes a discussion of the experimental design, the data collection procedures, and the statistical analysis techniques.


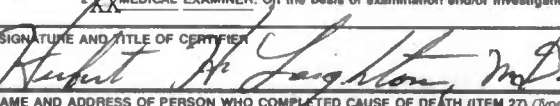
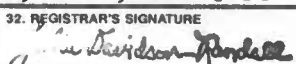
3. The third part of the report is a presentation of the results of the study. It includes a discussion of the findings, the interpretation of the data, and the conclusions drawn from the research.

4. The fourth part of the report is a summary of the findings and a discussion of the implications of the study. It includes a final conclusion and a list of references.

91 23531

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JERRY WALLACE SIMON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8 19 1991</b>		3. TIME OF DEATH <b>2:02 p m</b>	
4. SOCIAL SECURITY NUMBER <b>269-42-2200</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 28, 1945</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Garrett County Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Oakland</b>		9c. COUNTY OF DEATH <b>Garrett</b>	
10a. STATE <b>Ohio</b>				10b. COUNTY <b>Cuyahoga</b>		10c. CITY, TOWN OR LOCATION <b>S. Ueclid</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4774 Farnhurst Road</b>			
10f. ZIP CODE <b>44117</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Viet Nam</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Moving Lines</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Wallace L. Simon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ruby Phillips</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ruby P. Simon</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1713 Lavalette Ave. Elkins, W. Va. 26241</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Phillips Chapel Cemetery 8/22</b>		20c. LOCATION — City or Town, State <b>Jimtown, W. Va.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00167</b>				22. NAME AND ADDRESS OF FACILITY <b>P.O. Box 243 Durst Funeral Home - Oakland, Md. 21550</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ischemic Heart Disease</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Arteriosclerotic Cardio-Vascular Disease</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D 05658</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 19, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Herbert H. Leighton, M.D., Oak @ 5th Streets, Oakland, Maryland 21550</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 20 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>ALLEN W. SMITH</u>				2. DATE OF DEATH MONTH <u>August</u> DAY <u>5</u> YEAR <u>1991</u>		3. TIME OF DEATH <u>0627</u> M	
4. SOCIAL SECURITY NUMBER <u>217-16-9492</u>		5. SEX <u>1</u> M <u>2</u> F		6. AGE (In yrs. last birthday) <u>69</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11/15/21</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>				9a. FACILITY NAME (If not institution, give street and number) <u>PENINSULA GENERAL HOSPITAL</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>SALISBURY</u>	
9c. COUNTY OF DEATH <u>WICOMICO</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Wicomico</u>	
10c. CITY, TOWN OR LOCATION <u>Salisbury</u>				10d. INSIDE CITY LIMITS? <u>1</u> YES <u>2</u> NO		10e. STREET AND NUMBER <u>315 Craft Street</u>	
10f. ZIP CODE <u>21801</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		11. MARITAL STATUS <u>1</u> Never Married <u>2</u> Married <u>3</u> Widowed <u>4</u> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <u>1</u> YES <u>2</u> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>white</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>11</u> Elementary/Secondary (9-12) <u>2</u> College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Postal Employee</u>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <u>Charles B. Smith</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Bessie Mary Mister</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Edna S. Smith</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>315 Craft St., Salisbury, Md. 21801</u>			
20a. METHOD OF DISPOSITION <u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State <u>4</u> Donation <u>5</u> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Rehobeth Meth. Cem. 8/8</u>		20c. LOCATION — City or Town, State <u>Rehobeth, Md.</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Scott S. Melson</u>				22. NAME AND ADDRESS OF FACILITY <u>Melson Funeral Home</u> <u>PO BOX 64, Pocomoke, Md. 21851</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CARDIO-PULMONARY ARREST</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF): <u>CONGESTIVE HEART FAILURE</u>							
DUE TO (OR AS A CONSEQUENCE OF): <u>CORONARY ARTERY DISEASE</u>							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <u>1</u> YES <u>2</u> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <u>1</u> YES <u>2</u> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <u>1</u> YES <u>2</u> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA OTHER: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)			
27. MANNER OF DEATH <u>1</u> Natural <u>5</u> Pending Investigation <u>2</u> Accident <u>6</u> Could not be determined <u>3</u> Suicide <u>4</u> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>	
28c. INJURY AT WORK? <u>1</u> YES <u>2</u> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Dennis J. Chodnicki</u>				29c. LICENSE NUMBER <u>D20912</u>		29d. DATE SIGNED (Month, Day, Year) <u>8-5-91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Dennis J. Chodnicki Quincy Locust Sts., Salisbury, MD. 21801</u>							
31. DATE FILED (Month, Day, Year) <u>AUG 08 91</u>				32. REGISTRAR'S SIGNATURE <u>Jane Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91-23533

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE ROBERT SMITH</b>				2. DATE OF DEATH <b>AUGUST 11, 1991</b>		3. TIME OF DEATH <b>7:40pm</b>	
4. SOCIAL SECURITY NUMBER <b>217 32 3712</b>		5. SEX <b>XX</b> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>57</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08/04/'34</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>DOCTORS COMMUNITY HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>LANHAM-SEABROOK</b>		8c. COUNTY OF DEATH <b>PRINCE GEORGE'S CO.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Mitchellville</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>902 Crain Highway</b>				10f. ZIP CODE <b>20716</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>'54 - '57</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Boiler Engineer</b>		18b. KIND OF BUSINESS/INDUSTRY <b>Central Service</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Russell Smith, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosie Lee Spriggs</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charlotte Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>902 Crain Highway, Mitchellville, MD. 20716</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem</b>		DATE <b>August 11, 1991</b>		20c. LOCATION — City or Town, State <b>Cheltenham, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lloyd West</i>				22. NAME AND ADDRESS OF FACILITY <b>Adams Funeral Home, P.A. Aquasco Road, Aquasco, MD. 20608</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>metastatic pancreatic carcinoma</b> Approximate Interval Between Onset and Death <b>5 mos.</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David A. Batchelor, MD</i> Attending Physician				29c. LICENSE NUMBER <b>MD. D16063</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-12-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>David A. Batchelor, MD</i> <b>14300 Ballant Fox Ln., #118, Bowie, MD. 20715</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 '91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>MARY-LOUISE Sayers</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>14</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>7:32 A.</b>	
4. SOCIAL SECURITY NUMBER <b>229-40-1969</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/7/31</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Harford Memorial Hosp.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Harvre de Grace</b>		9c. COUNTY OF DEATH <b>Harford</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Aberdeen</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>80 East Bel Air Avenue Apt. A-9</b>				10f. ZIP CODE <b>21001</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>In home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Alex Stinson Hancock</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Violet Mae Eastwood</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sherwood W. Sayers</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>80 East Bel Air Ave., Apt. A-9 Aberdeen, MD 21001</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington National Cemetery 8/20</b>		20c. LOCATION — City or Town, State <b>Arlington, Virginia</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kirsten A. Unglesbee</b>				22. NAME AND ADDRESS OF FACILITY <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Myocardial Infarction</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cardiomyopathy. Ischemic Heart Disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFY (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>W. Mithani MD.</b>				29c. LICENSE NUMBER <b>D32609.</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kamrudin Mithani MD 703 Revolution st. Harvre de Grace MD 21078.</b>							
31. DATE FILED (Month, Day, Year) <b>Aug 16 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23535

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ricky J. Snyder</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>4</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:36 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-62-4669</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>36</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-10-1955</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Frostburg Community Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Frostburg</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Frostburg</b>		10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO	
10e. STREET AND NUMBER <b>90 West Mechanic Street</b>				10f. ZIP CODE <b>21532</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Real Estate Agent</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Real Estate</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Vernon D. Snyder</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy Boore</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Cindy L. Snyder</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 64 Eckhart, Md. 21528</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>6</b> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sunset Mem. Park</b>		DATE <b>8/7/91</b>		20c. LOCATION — City or Town, State <b>Cumberland, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ernest A. Rley-H.</b>				22. NAME AND ADDRESS OF FACILITY <b>Leasure-Stein, Inc. 230 Baltimore Av. Cumberland, Md. 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition) → <b>A.S.C.V.D.</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>6</b> Residence <b>6</b> Other (Specify)					
27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>8</b> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Francisco Reyes M.D. deputy M.E.</b>				29c. LICENSE NUMBER <b>D19316</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-4-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Francisco Reyes 900 Seton Drive Cumberland Md</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 06 1991</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





ITEMS:23 thru 28f per ME  
G-679 9/6/91 cm  
91-4528-510

91 23536

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Will Thor Sherman</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 07 1991</b>				3. TIME OF DEATH <b>7:24 A M</b>			
4. SOCIAL SECURITY NUMBER <b>220-80-2767</b>		5. SEX <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>32 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>01-18-59</b>		8. BIRTHPLACE (State or Foreign Country) <b>Texas</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Mercy Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <b><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>			
10e. STREET AND NUMBER <b>1422 Light Street #A</b>				10f. ZIP CODE <b>21230</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:</b>				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12 Elementary/Secondary (0-12) 2 College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Practical Nurse</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Nursing</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Will Sherman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elisabet Sigurdardottir</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Will Sherman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>695 Genessee Street, Annapolis, MD 21401</b>							
20a. METHOD OF DISPOSITION <b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		DATE <b></b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Beth J. [Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COMBINED DRUG AND ALCOHOL INTOXICATION</b> <b>Due to (or as a consequence of):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b></b>								24a. WAS AN AUTOPSY PERFORMED? <b><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>									
27. MANNER OF DEATH <b>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 8/7/91</b>		28b. TIME OF INJURY <b>6:45a M</b>		28c. INJURY AT WORK? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT USED DRUGS AND ALCOHOL</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>FOUND: HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1422 LIGHT ST BALTO., MD</b>									
29a. CERTIFIER (Check only one) <b>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] MD</b>						29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 07 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>T. Leon Locke MD 111 Penn Street, Baltimore Maryland 21201</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23537

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN KENNETH STONER</b>				2. DATE OF DEATH MONTH <b>AUGUST</b> DAY <b>14</b> , YEAR <b>1991</b>		3. TIME OF DEATH <b>9:00 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-16-0108</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MARCH 20, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>216 W. MAIN ST.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>EMMITSBURG</b>	
9c. COUNTY OF DEATH <b>FREDERICK</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>FREDERICK</b>	
10c. CITY, TOWN OR LOCATION <b>EMMITSBURG</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>216 W. MAIN ST.</b>	
10f. ZIP CODE <b>21727</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (13-16 or 17+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MANAGER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>STORE MANAGER</b>	
17. FATHER'S NAME (First, Middle, Last) <b>LOUIS H. STONER, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA BISHOP</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ANNA BAKER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16418 OLD EMMITSBURG RD. EMMITSBURG, MD. 21727</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>EMMITSBURG MEMORIAL</b>		20c. LOCATION — City or Town, State <b>EMMITSBURG, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Skiles</i>				22. NAME AND ADDRESS OF FACILITY <b>SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>						Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alcoholism</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew Zarick, Jr.</i>				29c. LICENSE NUMBER <b>D35614</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANDREW ZARICK, JR., M. D. 31-A EAST FREDERICK ST., WALKERSVILLE, MD. 21793</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William Carl Schnier				2. DATE OF DEATH MONTH DAY YEAR 08-09-91		3. TIME OF DEATH 2:20 AM M	
4. SOCIAL SECURITY NUMBER 579-44-5546		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 98 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06-01-93	
8. BIRTHPLACE (State or Foreign Country) St. Louis, MO				9a. FACILITY NAME (If not institution, give street and number) Pleasant Living Conv. Center		9b. CITY, TOWN OR LOCATION OF DEATH Edgewater	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE MD		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION West River				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5119 Holly Drive	
10f. ZIP CODE 20778				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Purchasing Executive		16b. KIND OF BUSINESS/INDUSTRY American Red Cross	
17. FATHER'S NAME (First, Middle, Last) Edward R. Schnier				18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Dietz			
19a. INFORMANT'S NAME (Type/Print) Elsie B. Schnier				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5119 Holly Drive, West River, MD 20778			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Christ Epis. Church Cemetery West River, MD		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas A. Hardesty				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 905 Galesville Road, Galesville, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure, Acute DUE TO (OR AS A CONSEQUENCE OF): Arterio Sclerotic Cardiomyopathy Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Cardiac Pacemaker for AV block Pneumonitis. Very advanced age.						Approximate Interval Between Onset and Death days years	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Julia Davidson-Randall				29c. LICENSE NUMBER D11653		29d. DATE SIGNED (Month, Day, Year) 8/9/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robt. F. VERKOUW M.D., 1833 Forest Dr. Annapolis MD 21401							
31. DATE FILED (Month, Day, Year) AUG 12 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Percy <i>Percy</i> <i>Adelayde</i> <i>Shriver</i> (Shriver)		2. DATE OF DEATH MONTH <i>08</i> DAY <i>18</i> YEAR <i>91</i>		3. TIME OF DEATH <i>12:45 P M</i>	
4. SOCIAL SECURITY NUMBER <i>266 52 0303</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>83</i> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <i>8/4/1908</i>		8. BIRTHPLACE (State or Foreign Country) <i>Md.</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Baltimore County Gen. Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Randallstown</i>		9c. COUNTY OF DEATH <i>Baltimore</i>	
10a. STATE <i>Md.</i>		10b. COUNTY <i>Carroll</i>		10c. CITY, TOWN OR LOCATION <i>Sykesville</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>7309 Second Ave.</i>		10f. ZIP CODE <i>21784</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>H.S.</i> College (1-4 or 5+) <i>0</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Percy Howard Shriver</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Adelayde McFadden</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Paul B. Butler, Jr.</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>33607-1458 6200 Courtney Campbell Causeway Tampa, Fla.</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Dominic Cemetery</i>		20c. LOCATION — City or Town, State <i>Philadelphia, Pa.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harry W. Haight</i>		22. NAME AND ADDRESS OF FACILITY <i>Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <i>Recurrent Aspiration Pneumonia</i> <i>Dementia</i>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Decubitus Ulcer</i> <i>Malnutrition</i>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert J. Moran</i>		29c. LICENSE NUMBER <i>032882</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/18/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)					
31. DATE FILED (Month, Day, Year) <i>AUG 20 '91</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson Anderson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEMS:23 thru 28f per ME  
G-679 9/27/91 cm

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FLOYD GORDON TURNER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>7-25-91</b>		3. TIME OF DEATH <b>8:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>216-92-9177</b>		5. SEX <b>1 M 2 F</b>		8. AGE (In yrs. last birthday) <b>26 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>11-08-64</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Stoney Creek</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rivera Beach</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>				10e. STREET AND NUMBER <b>808 WILDWOOD PKWY</b>		10f. ZIP CODE <b>21229</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b>				14. RACE — American Indian, Black, White, etc. <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>HIGH SCHOOL</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MECHANIC</b>				16b. KIND OF BUSINESS/INDUSTRY <b>MONTGOMERY WARDS</b>			
17. FATHER'S NAME (First, Middle, Last) <b>FLOYD GORDON TURNER SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MERVINA JOSEPHINE GROOMS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MERVINA TURNER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>808 WILDWOOD PKWY, BALTIMORE, MD. 21229</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WHITE ROCK CHURCH CEM. 09/16</b>		20c. LOCATION — City or Town, State <b>SYKESVILLE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>HARRY W. HAIGHT</b>				22. NAME AND ADDRESS OF FACILITY <b>HAIGHT F.H. BOX 115, SYKESVILLE, MD 21154</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → DROWNING COMPLICATING ALCOHOL AND COCAINE INTOXICATION</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>				26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) Stoney Creek</b>			
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>				28a. DATE OF INJURY (Month, Day, Year) <b>7-25-91</b>		28b. TIME OF INJURY <b>found 3:00P</b>	
28c. INJURY AT WORK? <b>1 YES 2 NO</b>				28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Found Stoney Creek</b>	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Rivera Beach</b>				28g. COUNTY <b>Anne Arundel County</b>			
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>A.M. DIXON</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 26, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.M. DIXON 111 Penn St. Baltimore, Md. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 20 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

P

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RALPH DARWIN SHURTZ				2. DATE OF DEATH MONTH DAY YEAR 08-10-91		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 214-34-3088		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-20-32	
8. BIRTHPLACE (State or Foreign Country) West Va.				9a. FACILITY NAME (If not institution, give street and number) 4855 Anchors Way		9b. CITY, TOWN OR LOCATION OF DEATH Galesville	
9c. COUNTY OF DEATH AA CO				10a. STATE MD		10b. COUNTY AA CO	
10c. CITY, TOWN OR LOCATION Galesville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4855 Anchors Way	
10f. ZIP CODE 20765				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th grade				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Survey		16b. KIND OF BUSINESS/INDUSTRY Computer	
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Linda Archambo				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4855 Anchors Way, Galesville, Md 20765			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro		20c. LOCATION — City or Town, State Baltimore, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia A. Smith</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home P.A., 12 Ridgely Ave., Annapolis, Md 21401			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>metastatic adenocarcinoma</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. _____ b. _____ c. _____ d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. W. Bolden</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) ▶	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) AUG 13 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

30 89201

91 23542

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE JACKSON SHIRES</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>14</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:30 A M</b>
4. SOCIAL SECURITY NUMBER <b>212-09-7738</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>78</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>6-16-13</b>	8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>
9a. FACILITY NAME (If not institution, give street and number) <b>Levindale Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT				
10a. STATE <b>Maryland</b>	10b. COUNTY	10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER <b>601 Wyanoake Ave., Apt. 507</b>		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (9-12)</b> <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sawyer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Saw Mill</b>
17. FATHER'S NAME (First, Middle, Last) <b>Harry W. Shires</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edna Cosner</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Tommie Shires</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1312 River Rd., Crownsville, Maryland 21032</b>		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Reinterment from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, INC. 8/18/91</b>		20c. LOCATION — City or Town, State <b>Catonsville, Balto, MD</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Kirkley Funeral Home 421 Crain Hwy. S.E., Glen Burnie, MD 21061</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC PHARYNGEAL CANCER</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death <b>5 months</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>ATTENDING MD</b>		29c. LICENSE NUMBER <b>D30951</b>	29d. DATE SIGNED (Month, Day, Year) <b>8-14-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>AT LUCCO 2434 W BELVEDERE AVE BALTIMORE 21215</b>				
31. DATE FILED (Month, Day, Year) <b>AUG 16 1991</b>		32. REGISTRAR'S SIGNATURE 		

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91 23543

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Ethel Lona Stottlemeyer</i>				2. DATE OF DEATH MONTH <i>8</i> DAY <i>14</i> YEAR <i>91</i>		3. TIME OF DEATH <i>11:45 a. m.</i>	
4. SOCIAL SECURITY NUMBER <i>212-74-4893</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>10-16-1902</i>	
8. BIRTHPLACE (State or Foreign Country) <i>MD.</i>				9a. CITY, TOWN OR LOCATION OF DEATH <i>Clear Spring,</i>		9c. COUNTY OF DEATH <i>Washington</i>	
9b. FACILITY NAME (If not institution, give street and number) <i>12130 Cove Rd.</i>							
10a. STATE <i>MD.</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Clear Spring,</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>12130 Cove Rd.</i>				10f. ZIP CODE <i>21722</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>House</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Charles Martin Shank</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Virginia Frush</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Louise Stottlemeyer</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12130 Cove Rd. Clear Spring, MD. 21722</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, church, or other place) <i>St. Paul Cemetery 8-16</i>		20c. DATE <i>8-16</i>		20d. LOCATION — City or Town, State <i>Clear Spring, MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edmond T. Davis</i>				22. NAME AND ADDRESS OF FACILITY <i>Donald E. Thompson Funeral Home, Inc. P.O. Box 310 Clear Spring, MD. 21722</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i>						Approximate Interval Between Onset and Death <i>10 minutes</i>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Brull MD. Personal Physician</i>				29c. LICENSE NUMBER <i>204359</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/15/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert Brull MD. 1459 Potomac Ave Hagerstown</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 16 '91</i>		32. REGISTRAR'S SIGNATURE <i>Jill Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23544

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John W. Jr. Tatem</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 13 1991</b>		3. TIME OF DEATH <b>6:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>225-40-4239</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>74 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>8/23/1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Pocomoke City</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>206 Fourteenth Street</b>				10f. ZIP CODE <b>21851</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>US Coast Guard WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>6</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Teacher &amp; Principal</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>John W. Tatem, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lottie Booth</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Luella H. Tatem</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>206 14th St., Pocomoke, Md. 21851</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Pitts Creek Pres. Cem. 8/16 Pocomoke, Md.</b>		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Scott S. Melon</b>				22. NAME AND ADDRESS OF FACILITY <b>Melson Funeral Home PO BOX 64, Pocomoke City, Md. 21851</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ventricular Fibrillation</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Coronary Artery Disease</b>						Approximate Interval Between Onset and Death <b>hours</b> <b>years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Jeffrey E. Herton, M.D.</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>08/13/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jeffrey E. Herton, M.D. Peninsula General Hospital, Salisbury, Md.</b>				31. DATE FILED (Month, Day, Year) <b>AUG 15 91</b>			
32. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jon Ramon AKA John Raymond Tucker</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>29</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:07 P M</b>	
4. SOCIAL SECURITY NUMBER <b>542-28-4208</b>		5. SEX <b>XX M</b> 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-27-23</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Greenock, MD</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>1829 Aliceanna St.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1829 Aliceanna Street</b>				10f. ZIP CODE <b>21200</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <b>XX Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Insurance</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Elbert Hamilton Tucker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elsie May Mardesty</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mariam Hardesty</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6033 Fischer Station Road, Lothian, MD 20711</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Crestlawn Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Pat J. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ethanol Abuse</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <b>XX</b> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 30, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald G. Wright M.D. 111 Penn St. Baltimore, Md. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23546

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Thomas THOMAS</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>9:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-28-4407</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-18-1913</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Nursing Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>A.A. Co</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>DAVIDSONVILLE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3583 RIVA ROAD</b>				10f. ZIP CODE <b>21035</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W.II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PAINTER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. NAVAL ACADEMY</b>	
17. FATHER'S NAME (First, Middle, Last) <b>EMANUEL THOMAS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JULIA STEWART</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DAISY E. BROWN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>400 MILL SWAMP RD. EDGEWATER, MD. 21037</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>UNION MEM. CHURCH CEMETERY</b>		20c. LOCATION — City or Town, State <b>DAVIDSONVILLE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Larry G. Reese</b>				22. NAME AND ADDRESS OF FACILITY <b>821 WEST ST. ANNAPOLIS, MD. 21401</b> <b>REESE &amp; SONS MORTUARY, P.A.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Carcinoma of prostate</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): <b>2<sup>o</sup> Anemia</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>arteriosclerosis</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mustafa C. O2 MD</b>				29c. LICENSE NUMBER <b>D 22206</b>		29d. DATE SIGNED (Month, Day, Year) <b>8.12.91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MUSTAFA C. O2 MD</b>				31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>			
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23547

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NATHAN LUTHER VALENTINE, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Aug. 16, 1991</b>		3. TIME OF DEATH <b>9:05 a. M.</b>	
4. SOCIAL SECURITY NUMBER <b>174-05-3867</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-10-1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Meridian HealthCare</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Frederick</b>		9c. COUNTY OF DEATH <b>Frederick</b>	
10a. STATE <b>MD.</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Thurmont</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>14732 Sabillasville Rd.</b>				10f. ZIP CODE <b>21788</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Alban Tractors, Inc.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Nathan Luther Valentine, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cora Florence Shearer</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donald Valentine</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Tacoma St., Thurmont, Md. 21788</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Resthaven Memorial Gardens 8/20/91</b>		20c. LOCATION — City or Town, State <b>Frederick, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald L. Lemmer</i>				22. NAME AND ADDRESS OF FACILITY <b>Stauffer Funeral Home, P.O. Box 1819 Frederick, Maryland 21702</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory arrest</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Congestive Heart Failure</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D17549</b>		29d. DATE SIGNED (Month, Day, Year) ►	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>AUG 19 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

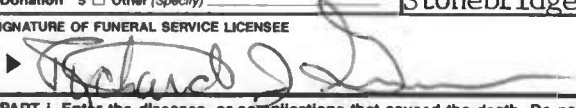

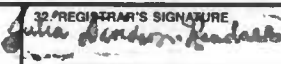
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91 23548

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Della M. Weller</b>		2. DATE OF DEATH MONTH <b>7</b> DAY <b>26</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1425</b> M
4. SOCIAL SECURITY NUMBER <b>217-32-5148</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>86</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>March 8, 1905</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Hancock, Maryland</b>				
9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>
RESIDENCE OF DECEDENT				
10a. STATE <b>Maryland</b>	10b. COUNTY <b>Washington</b>	10c. CITY, TOWN OR LOCATION <b>Boonsboro</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>141 S. Main Street</b>		10f. ZIP CODE <b>21713</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Agriculture</b>
17. FATHER'S NAME (First, Middle, Last) <b>Dallas Moats</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Elmeta E. Keefer</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>HRC 81 Box 161 Needmore, Pa. 17238</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Stonebridge Cemetery 7/30/91</b>		20c. LOCATION — City or Town, State <b>Hancock, Maryland</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Grove Funeral Home 141 West Main Street Hancock, Md. 21750</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. massive brainstem vascular thrombosis</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b>  <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b>  <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic atrial flutter with paroxysms</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D32518</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-27-91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				
31. DATE <b>AUG 27 1991</b>				
32. REGISTRAR'S SIGNATURE 				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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4/10/12

184

91 23549

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GUY RAYMOND WHITE, SR.</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>17</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:15 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>213-26-9356</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-13-1928</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9. COUNTY OF DEATH <b>Prince Georges</b>			
10. FACILITY NAME (If not institution, give street and number) <b>So. Maryland Hospital</b>				11. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>		12. COUNTY OF DEATH <b>Prince Georges</b>	
13. STATE <b>MARYLAND</b>		14. COUNTY <b>PRINCE GEORGE'S</b>		15. CITY, TOWN OR LOCATION <b>BRANDYWINE</b>		16. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
17. STREET AND NUMBER <b>8409 OAK DRIVE</b>				18. ZIP CODE <b>20613</b>		19. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
20. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		23. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+) <b>College</b>				25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BREAD/BAKERY SALEMAN</b>		26. KIND OF BUSINESS/INDUSTRY <b>FOOD SERVICE</b>	
27. FATHER'S NAME (First, Middle, Last) <b>LAWRENCE R. WHITE</b>				28. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ARLENE BUCKLER</b>			
29. INFORMANT'S NAME (Type/Print) <b>MARION E. WHITE</b>				30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8409 OAK DRIVE, BRANDYWINE, MARYLAND 20613</b>			
31. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>TRINITY MEMORIAL GARDENS</b>		33. DATE <b>8-20</b>		34. LOCATION — City or Town, State <b>WALDORF, MARYLAND</b>	
35. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>MICHAEL K. BLANKENSHIP, MO0857</b>				36. NAME AND ADDRESS OF FACILITY <b>THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156</b>			
37. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal Failure</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. <b>perforated viscus</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Advanced emphysema</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>Coronary artery disease</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
e. <b>Serious</b>							
f. <b>Sepsis</b>							
38. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
40. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		41. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
42. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		43. DATE OF INJURY (Month, Day, Year) <b>8/17/91</b>		44. TIME OF INJURY <b>3:15 PM</b>		45. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
46. DESCRIBE HOW INJURY OCCURRED		47. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>SMH</b>		48. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
49. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
50. SIGNATURE AND TITLE OF CERTIFIER <b>B. REDJAE</b>				51. LICENSE NUMBER <b>039691</b>		52. DATE SIGNED (Month, Day, Year) <b>8/17/91</b>	
53. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B. REDJAE, 4467 Old Branch Rd, Temple Hills</b>							
54. DATE FILD (Month, Day, Year) <b>AUG 20 '91</b>		55. REGISTRAR'S SIGNATURE <b>Johanna Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21522 12

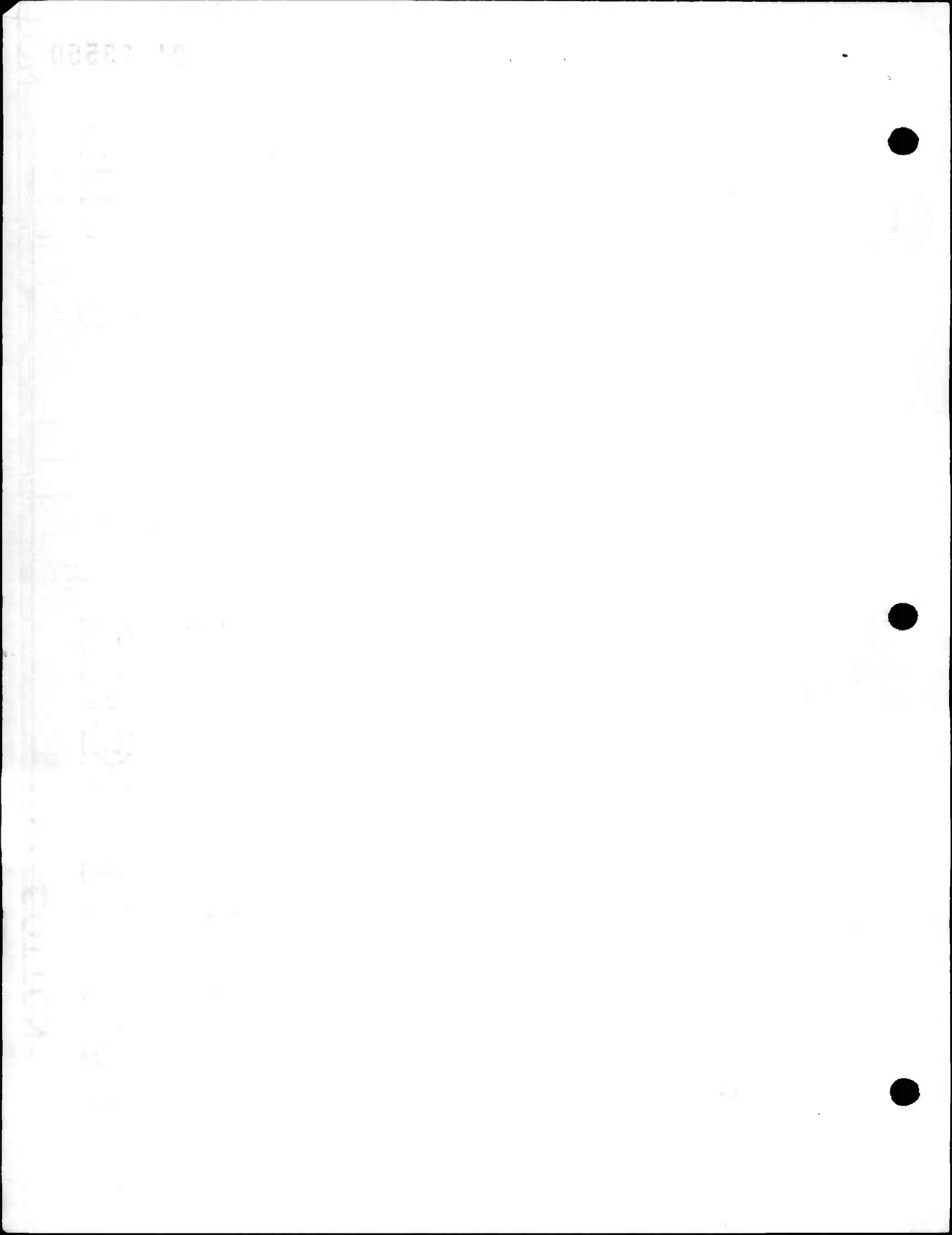
1 - FOR  
STATE  
REGISTER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ORVILLE LEE Williams</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>5</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2330</b>							
4. SOCIAL SECURITY NUMBER <b>222-07-4416</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>76</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>MAY 1, 1915</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>							
RESIDENCE OF DECEDENT													
10a. STATE <b>VIRGINIA</b>		10b. COUNTY <b>ACCOMACK CO.</b>		10c. CITY, TOWN OR LOCATION <b>SANFORD</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>SAXIS ROAD</b>				10f. ZIP CODE <b>23426</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW 11</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th GRADE</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MERCHANT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>GENERAL STORE</b>									
17. FATHER'S NAME (First, Middle, Last) <b>RALPH C. WILLIAMS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LACIE WHITE</b>									
19a. INFORMANT'S NAME (Type/Print) <b>MRS. HILDA DENNIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>WATTSVILLE, VA</b>									
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DOWNING CEME. OAK HALL, VA</b>		DATE <b>8/8/91</b>		20c. LOCATION — City or Town, State <b>OAK HALL, VA 23416</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dan N. Fay</b>				22. NAME AND ADDRESS OF FACILITY <b>FOX FUNERAL HOME P.O. BOX 278 LANKFORD HIGHWAY, TEMPERANCEVILLE, VA 23442</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>							Approximate Interval Between Onset and Death						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>6</b> <input type="checkbox"/> Could not be determined <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Benjamin H. Meyer</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Benjamin Meyer - Quincy + Locust Street - Sal. Md. 21801</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 07 91</b>				32. REGISTRAR'S SIGNATURE <b>John Burdon - Hordle</b>									

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES L. WAITE, JR.</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>11</b> YEAR <b>1911</b>		3. TIME OF DEATH <b>M</b>							
4. SOCIAL SECURITY NUMBER <b>215-38-1578</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (in yrs. last birthday) <b>56</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>03-24-35</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>							
RESIDENCE OF DECEDENT													
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Snow Hill</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>6215 Timmons Road</b>				10f. ZIP CODE <b>21863</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farmer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Truck Farm</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Charles L. Waite Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Naomi Townsend</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Carol W. Waite</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6215 Timmons Rd., Snow Hill, Maryland 21863</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Bates Meth. Cemetery</b>		DATE <b>14</b>	20c. LOCATION — City or Town, State <b>Snow Hill, Maryland</b>								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Dennis Funeral Home</b> <b>110 Franklin St., Snow Hill, Md. 21863</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):						YEARS					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):											
		c. DUE TO (OR AS A CONSEQUENCE OF):											
		d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <b>DEPUTY, M.E.</b>		29c. LICENSE NUMBER <b>D03599</b>		29d. DATE SIGNED (Month, Day, Year) <b>08-11-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN T. BULKELEY, M.D. 108 PINE BLUFF ROAD SALISBURY, MD 21801</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE 											





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN BERNARD WENTLING</b>				2. DATE OF DEATH MONTH DAY YEAR <b>JULY 31, 1991</b>		3. TIME OF DEATH <b>13:10 P<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>214 12 3164</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC 15 1901</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>CUMBERLAND</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>RFD# 5 BOX# 5 GARDEN CITY</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MAINTANCE MANAGER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CONSTRUCTION/MAINTANCE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>BERNARD A. WENTLING</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA FLAKE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS BETTY STEELE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RFD# 5 BOX# 5 GARDEN CITY CUMBERLAND MARYLAND</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HILLCREST BURIAL PARK AUG 3 1991 CUMBERLAND MD.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY <b>SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Bilateral Aspiration pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Sepsis</b> <b>Wbsepsis</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				27a. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY <b>M</b>	
27b. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				27c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		27d. DESCRIBE HOW INJURY OCCURRED	
28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Fadel</i>				29c. LICENSE NUMBER <b>16150</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-1-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. RAGAA FADL, M.D., 921 SETON DRIVE, CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 06 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Harrison</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 08225

91-4503-023

91 23553

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Roger Allen Wilhelm</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>04</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>6:00 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>218-70-1567</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>25</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 4, 1966</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Garret County Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Oakland</b>	
9c. COUNTY OF DEATH <b>Garrett</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Garrett</b>	
10c. CITY, TOWN OR LOCATION <b>Grantsville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Star Route, Box 178</b>	
10f. ZIP CODE <b>21536</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mill Worker</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Bakery</b>	
16. DECEDENT'S FATHER'S NAME (First, Middle, Last) <b>Allen Wilhelm</b>				16. DECEDENT'S MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alice Bowman</b>			
17. INFORMANT'S NAME (Type/Print) <b>Alice Smith</b>				17. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>211 Dundee St.; Mt. Lake Park, MD 21550</b>			
18. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				18a. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Grantsville Cemetery 8/7/</b>		18b. LOCATION — City or Town, State <b>Grantsville, MD</b>	
19. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>A. Lynn Spemann</i>				20. NAME AND ADDRESS OF FACILITY <b>Newman Funeral Homes, P.A. Grantsville, Maryland 21536</b>			
21. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Injuries</b> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
22. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							
23. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>DRIVER (FD)</b>		25. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
26. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28. DATE OF INJURY (Month, Day, Year) <b>08 04 1991</b>	
29. TIME OF INJURY <b>3:45a</b>				29. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		30. DESCRIBE HOW INJURY OCCURRED <b>Occupant in motor vehicle Accident</b>	
31. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>On street</b>				32. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Alt. Rte. 40 3 miles (W) of Grantsville</b>			
33. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
34. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				35. LICENSE NUMBER <b>O.C.M.E.</b>		36. DATE SIGNED (Month, Day, Year) <b>08 05 1991</b>	
37. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANK J. PERETTI, 111 Penn Street, Baltimore Maryland 21201</b>							
38. DATE FILED (Month, Day, Year) <b>AUG 08 1991</b>				39. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23554

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNA CATHERINE WITT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 8, 1991</b>		3. TIME OF DEATH <b>5:25 AM</b>	
4. SOCIAL SECURITY NUMBER <b>208 09 5723</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01/15/1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>PA</b>		10b. COUNTY <b>SOMERSET</b>		10c. CITY, TOWN OR LOCATION <b>HYNDMAN</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>R D 1, BOX 253A</b>				10f. ZIP CODE <b>15545</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>HOMEMAKER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>PHILLIP EDWARD DELBROOK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELLEN SHUMAKER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY SUSAN DIEHL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>ROUTE 1, MT. SAVAGE, MD 21545</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>COOK CEMETERY 8/11/91</b>		20c. LOCATION — City or Town, State <b>RD, HYNDMAN, PA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Harvey H. Zeigler</i>				22. NAME AND ADDRESS OF FACILITY <b>HARVEY H. ZEIGLER FUNERAL HOME CLARENCE ST., HYNDMAN, PA 15545</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal failure</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Seizures</b>  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerosis</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. J. Poonai</i>		29c. LICENSE NUMBER <b>D36766</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUGUST 8, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. VIC POONAI, M.D., 955 FREDERICK STREET, CUMBERLAND, MD 21502</b>							
31. DATE OF FILING (Month, Day, Year) <b>AUG 09 1991</b>		32. REGISTRAR'S SIGNATURE <i>J. Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Alice Mabel Willett</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-14-5745</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Mar. 29, 1905</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maine</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Howard County General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>	
9c. COUNTY OF DEATH <b>Howard</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Arnold</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1478 Grandview Road</b>	
10f. ZIP CODE <b>21012</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John N. McNamara</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katie May Lancaster</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Richard Bonnett</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1478 Grandview Road, Arnold, MD 21012</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Willcrest Cemetery</b>		20c. LOCATION — City or Town, State <b>Annapolis, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald A. Lytle</i>				22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>aspiration pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death <b>24 hrs</b> <b>7 days</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>atrial fibrillation</b> <b>Alzheimers</b> <b>Renal insufficiency</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lynn D. Alonso, MD</i>				29c. LICENSE NUMBER <b>D 32 482</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LYNN D. ALONSO TWO KNOLL NORTH DR., COLUMBIA, MD 21045</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23556

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>George H. Williams</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>223-20-7403</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12 25 1903</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>MARYLAND MANOR NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>				9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>ANNAPOLIS</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>29 ARBOR HILL RD.</b>				10f. ZIP CODE <b>21403</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ORDERLY</b>				16b. KIND OF BUSINESS/INDUSTRY <b>A.A. GENERAL HOSPITAL</b>	
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE WILLIAMS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY ANN BRYANT</b>					
19a. INFORMANT'S NAME (Type/Print) <b>JOHN HILL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>29 ARBOR HILL RD. ANNAPOLIS, MD. 21403</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HILL CREST CEMETERY</b>				20c. LOCATION — City or Town, State <b>ANNAPOLIS, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Larry H. Reese</b>				22. NAME AND ADDRESS OF FACILITY <b>821 WEST ST ANNAPOLIS, MD. 21401 REESE &amp; SONS MORTUARY, P.A.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. <b>probable cardiac arrhythmia minutes before death</b>									
b. <b>due to (OR AS A CONSEQUENCE OF):</b>									
c. <b>due to (OR AS A CONSEQUENCE OF):</b>									
d. <b>due to (OR AS A CONSEQUENCE OF):</b>									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>probable malnutrition Right lung</b>									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James D. Starnbek</b>				29c. LICENSE NUMBER <b>D29767</b>				29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Setry D. STARNBEK 8418 BTA Blvd Pasadena MD 21122</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 33228

91 23557

(91-23557)

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Evelyn L. Ward</u>				2. DATE OF DEATH MONTH <u>08</u> DAY <u>16</u> YEAR <u>1991</u>				3. TIME OF DEATH <u>8:45P</u> M	
4. SOCIAL SECURITY NUMBER <u>212 32 1440</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>75</u> YRS.		IF UNDER 1 YEAR MONTHS <u>    </u> DAYS <u>    </u>		IF UNDER 24 HRS. HOURS <u>    </u> MIN. <u>    </u>	
7. DATE OF BIRTH (Month, Day, Year) <u>04-07-1916</u>				8. BIRTHPLACE (State or Foreign Country) <u>SC</u>					
9a. FACILITY NAME (If not institution, give street and number) <u>214 N. Union Avenue</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Havre de Grace</u>				9c. COUNTY OF DEATH <u>Harford</u>	
10a. STATE <u>MD</u>		10b. COUNTY <u>Harford</u>		10c. CITY, TOWN OR LOCATION <u>Havre de Grace</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>214 N. Union Avenue</u>				10f. ZIP CODE <u>21078</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>    </u> College (1-4 or 5+) <u>5</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>(Ret) Registered Nurse</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Doctors Office</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Addison Leroy Lewis, M.D.</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Edith Ervin</u>					
19a. INFORMANT'S NAME (Type/Print) <u>Mr. Wilbur S. Ervin</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1009 Leslie Rd., Havre de Grace, MD 21078</u>					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>R. A. Ferris &amp; Co., Inc 8/17</u>				20c. LOCATION — City or Town, State <u>West Chester, PA</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>William S. Ervin</u>				22. NAME AND ADDRESS OF FACILITY <u>Mitchell-Smith Funeral Home, P.A. Havre de Grace, MD 21078-3197</u>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Ca. of the lungs with metastasis</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>    </u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>    </u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>    </u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>    </u>								Approximate Interval Between Onset and Death <u>one year</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Heavy Cigarette Smoking for years</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <u>    </u>		28b. TIME OF INJURY <u>    </u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <u>    </u>	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <u>    </u>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <u>    </u>					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <u>E. C. Loo, M.D.</u>				29c. LICENSE NUMBER <u>D05676</u>		29d. DATE SIGNED (Month, Day, Year) <u>8/17/91</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>E. C. Loo, M.D. Union Medical Clinic, Havre de Grace, Md.</u>									
31. DATE FILED (Month, Day, Year) <u>AUG 16 '91</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23558

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>YOUNG AE YOO</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 16, 1991</b>		3. TIME OF DEATH <b>05:15 PM</b>	
4. SOCIAL SECURITY NUMBER <b>545-55-2196</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 8, 1910</b>	
8. BIRTHPLACE (State or Foreign Country) <b>SEOUL, KOREA</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>2044 ABBEY COURT</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>WALDORF</b>	
9c. COUNTY OF DEATH <b>CHARLES</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>CHARLES</b>				10c. CITY, TOWN OR LOCATION <b>WALDORF</b>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>2044 ABBEY COURT</b>			
10f. ZIP CODE <b>20602</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>KOREAN</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+) <b>COLLEGE</b>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>	
17. FATHER'S NAME (First, Middle, Last) <b>NOK IL YOO</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>KAHN NUN HYOUNG</b>			
19a. INFORMANT'S NAME (Type/Print) <b>HOWARD D. BLAIR</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2044 ABBEY COURT, WALDORF, MARYLAND 20602</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>TRINITY MEMORIAL GARDENS</b>		20c. LOCATION — City or Town, State <b>WALDORF, MARYLAND</b>	
21. SIGNATURE OF PHYSICIAN (Type/Print) <b>MICHAEL K. BLANKENSHIP, MD0857</b>				22. NAME AND ADDRESS OF FACILITY <b>THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>ACUTE CARDIOPULMONARY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>END STAGE OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE.</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>CACHEXIA AND DEPRESSION, REACTIVE</b> DUE TO (OR AS A CONSEQUENCE OF):							
d. <b>SEVERE DEGENERATIVE JOINT DISEASE,</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CEREBRAL ARTERIOSCLEROSIS WITH RECURRENT SYNCOPES.</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Peter W. Yim</b>				29c. LICENSE NUMBER <b>D12884</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUG. 17 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PETER W. YIM M.D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON, MARYLAND 20735</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 20 91</b>				32. REGISTRAR'S SIGNATURE <b>Jane Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 7, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23559

1. DECEDENT'S NAME (First, Middle, Last) <i>Samuel Lynn Zimmerman, Sr.</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Aug. 13, 1991</i>		3. TIME OF DEATH <i>12:00 P.</i>				
4. SOCIAL SECURITY NUMBER <i>220-28-3487</i>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>70</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>May 28, 1921</i>		8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>		
9a. FACILITY NAME (If not institution, give street and number) <i>12132 Loy Wolf Rd.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Myersville</i>			9c. COUNTY OF DEATH <i>Frederick</i>			
10a. STATE <i>MD</i>		10b. COUNTY <i>Frederick</i>		10c. CITY, TOWN OR LOCATION <i>Myersville</i>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <i>12132 Loy Wolf Rd.</i>				10f. ZIP CODE <i>21773</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Machine Operator</i>			15b. KIND OF BUSINESS/INDUSTRY <i>County Roads</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Luther Martin Zimmerman</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Margaret Ellen Keffer</i>						
19a. INFORMANT'S NAME (Type/Print) <i>Delphine L. Zimmerman</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12132 Loy Wolf Rd. Myersville, MD 21773</i>						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Salem United Methodist Cemetery</i>			20c. LOCATION — City or Town, State <i>Wolfsville, MD</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis L. Davis</i>				22. NAME AND ADDRESS OF FACILITY <i>Ricketts Funeral Home 504 Main St. Myersville, MD 21773</i>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>metastatic Prostate Carcinoma Error with kidneys</i> a. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <i>?</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William B. Kerns MD</i>				29c. LICENSE NUMBER <i>838471</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/15/91</i>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Wm B Kerns MD</i>										
31. DATE FILED (Month, Day, Year) <i>AUG 15 91</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>								

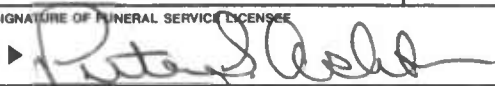

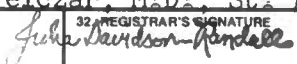
00000 12



91 23560

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS T. ARMSTRONG, JR.				2. DATE OF DEATH MONTH DAY YEAR 8/ 28/ 91		3. TIME OF DEATH 11:30 a.m.	
4. SOCIAL SECURITY NUMBER 214-20-8270		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/4/27	
9a. FACILITY NAME (If not institution, give street and number) 9321 Ramsey Drive				9b. CITY, TOWN OR LOCATION OF DEATH Ellicott City		9c. COUNTY OF DEATH Howard	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 1887 Norhurst Way				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 6-2-45 8-1-46		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Meat Grader		16b. KIND OF BUSINESS/INDUSTRY Fed. Government			
17. FATHER'S NAME (First, Middle, Last) Thomas T. Armstrong, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pauline Farson			
19a. INFORMANT'S NAME (Type/Print) Warren Armstrong				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Marathon Ct. Apt 2B Balto, Md. 21228			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park		20c. LOCATION — City or Town, State Baltimore			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home 736 Edmondson Avenue Balto 21228					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Myocardial Infarction, Acute, Posterior DUE TO (OR AS A CONSEQUENCE OF):							
b. Occlusion, Atherosclerotic, Posterior Bypass DUE TO (OR AS A CONSEQUENCE OF):							
c. Graft Vessel DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.				29c. LICENSE NUMBER D09990		29d. DATE SIGNED (Month, Day, Year) 8/29/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael E. Pelczar, M.D., St. Agnes Hospital, 900 Caton Ave., Balto., Md. 21229							
31. DATE FILED (Month, Day, Year) AUG 30 1991		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 23561

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>EDWARD C. ATKINSON</b>				2. DATE OF DEATH AUGUST 27 1991		3. TIME OF DEATH 1:30 P M					
4. SOCIAL SECURITY NUMBER 578-48-8196		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 3, 1935		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.			
9a. FACILITY NAME (If not institution, give street and number) 9833 BROOKRIDGE COURT				9b. CITY, TOWN OR LOCATION OF DEATH MONTGOMERY VILLAGE			9c. COUNTY OF DEATH MONTGOMERY				
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Montgomery Village			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 9833 Brookridge Court				10f. ZIP CODE 20879		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1955		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Limousine Owner/Operator		16b. KIND OF BUSINESS/INDUSTRY Limousine Company							
17. FATHER'S NAME (First, Middle, Last) Harry Comb Atkinson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Mae Burnside							
19a. INFORMANT'S NAME (Type/Print) Christine M. Sweet				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1403 Pennington Lane, Bowie, Maryland 20716							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven		20c. LOCATION — City or Town, State Silver Spring, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Muriel H. Barber</i>				22. NAME AND ADDRESS OF FACILITY Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coma - hepatic failure</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>arteriosclerotic heart disease</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald L. Bucy M.D.</i>		29c. LICENSE NUMBER D00957		29d. DATE SIGNED (Month, Day, Year) 8-28-91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald L. Bucy 809 Veirs Mill Rd Rockville Md 20851											
31. DATE FILED (Month, Day, Year) AUG 30 1991		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>									

12522

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this is filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23562

1. DECEDENT'S NAME (First, Middle, Last) <b>George N. Blanchfield</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG 23 1991</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>219-42-5896</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 19, 1930</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>MERRIDIAN LONG GREEN</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>Phoenix</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3 Dalebrook Drive</b>	
10f. ZIP CODE <b>21131</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Nursing Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William H. Blanchfield</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ETHEL HENLOW</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Family Records</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FAIRVIEW Church Cemetery 8/27/91</b>			
20c. LOCATION — City or Town, State <b>Phoenix, Md.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert W. Goveas</b>			
22. NAME AND ADDRESS OF FACILITY <b>EVANS Chapel of Chimes 2325 York Rd. Timonium, Md. 21093</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Emphysema</b> <b>Coronary artery disease</b>			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>8/26/91</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Robert Vissing</b>				29c. LICENSE NUMBER <b>D33897</b>			
29d. DATE SIGNED (Month, Day, Year) <b>8/26/91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert Vissing 4300 N. Charles St</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>Jenia Davidson-Randell</b>			

SA298 109

91 23563

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THOMAS A. BOSTON, SR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG. 21, 1991</b>		3. TIME OF DEATH M <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>216-36-7771</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>51</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 23, 1939</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CARROLL COUNTY GEN. HOSP.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>WESTMINSTER</b>		9c. COUNTY OF DEATH <b>CARROLL CO.</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>CARROLL CO.</b>		10c. CITY, TOWN OR LOCATION <b>WESTMINSTER</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>202 EAST MAIN STREET</b>			
10f. ZIP CODE <b>21157</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>-</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PAINTER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>R.W. BOSTON</b>	
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN BOSTON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GRACE WARREN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FAMILY RECORDS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ABOVE</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARKWOOD CEM. 8/24 PARKVILLE, MD.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jeffrey L. Gair</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS FUNERAL CHAPEL</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction (Atherosclerosis)</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Sepsis</b> b. <b>Dehydration</b> c. <b>Due to (OR AS A CONSEQUENCE OF):</b> d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER <b>D25443</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/22/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>11130 Batt Blvd Westminster Md 21157</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0. 23223



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Office of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE		91 23564	
CERTIFICATE OF DEATH		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) RUSSELL EDGAR BOSLEY		2. DATE OF DEATH MONTH 8 DAY 22 YEAR 91		3. TIME OF DEATH 11:20A M	
4. SOCIAL SECURITY NUMBER 214 14 4239	5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5 21 21	
8. BIRTHPLACE (State or Foreign Country) BALTIMORE		9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH TOWSON	
9c. COUNTY OF DEATH BALTIMORE		10a. STATE MD		10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION TOWSON		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1436 PROVIDENCE RD	
10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American-Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) —		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) RAILROAD ENGINEER		16b. KIND OF BUSINESS/INDUSTRY PENNN. RAILROAD	
17. FATHER'S NAME (First, Middle, Last) TOLLIE EDGAR BOSLEY		18. MOTHER'S NAME (First, Middle, Maiden Surname) METHA EVELYN SNYDER		19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of institution, crematory or other place) PARKWOOD CEM. 8/26 PARKVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey L. Gair		22. NAME AND ADDRESS OF FACILITY EVANS FUNERAL CHAPEL 8300 HARFORD ROAD		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. COPD DUE TO (OR AS A CONSEQUENCE OF): c. PROSTATE CA BONE METASTATIC DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. SIGNATURE AND TITLE OF CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. LICENSE NUMBER MD 3263		29c. DATE SIGNED (Month, Day, Year) 8/25/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TIMOTHY HERLIHY, M.D G.B.M.C 6701 N CHARLES ST		31. DATE FILED (Month, Day, Year) AUG 30 1991		32. REGISTRAR'S SIGNATURE John Davidson-Randall	

2. 03224

91 23565

FOR STATE REGISTRAR  
 1 - STATE REGISTRAR  
 Item; 24a, per M.D. reb  
 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH  
 REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Milton Butler</b>		2. DATE OF DEATH MONTH <b>08</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:15 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>217-07-4893</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>84</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>1-3-07</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Villa St Michael 4800 Sehn Dr</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto.</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Randallstown</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>8800 Winterbrook Road</b>		10f. ZIP CODE <b>21133</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Electric Technician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>General Electric</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Butler</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>Richard A. Butler</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8800 Winterbrook Road Randallstown, MD 21133</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery 8/31 Baltimore Co., MD</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Vivian O Nutter</b>		22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Chronic Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Chronic Renal Insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Hypertension</b> Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death <b>Minutes</b> <b>Months</b> <b>Months</b> <b>Years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 10 <input type="checkbox"/> Nomicide 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mishulam MD</b>		29c. LICENSE NUMBER <b>D38675</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8/28/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOEL MESHULAM 302 GREENSPRING STATION LUTHERVILLE MD 21093</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>		32. REGISTRAR'S SIGNATURE <b>La Davidson-Randall</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



ITEMS: 6, 7, 10b, 10c, 12, 17, 18  
per FH G-679 9/5/91 cm

91 23566

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES BARCO</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>28</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>10:42 AM</b>									
4. SOCIAL SECURITY NUMBER <b>242013303</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH MONTH <b>3</b> DAY <b>1</b> YEAR <b>20</b>		8. BIRTHPLACE (State or Foreign Country) <b>N.C.</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOSPITAL CORPORATION</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH							
10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY TURNERS STATION</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>300 Chestnut <del>XX</del> St.</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1944-1946</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>Bethlehem Steel</b>											
17. FATHER'S NAME (First, Middle, Last) <b>Willie Barco</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cherie Elliott</b>				CHENIE ELLIOTT							
19a. INFORMANT'S NAME (Type/Print) <b>Willie Barco</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>300 Chestnut St. BALTO. MD 21222</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		DATE <b>8/3/91</b>		20c. LOCATION — City or Town, State <b>Owings Mills</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James A. Morton</b>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Son 3701 LAURELS ST.</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ADENOCARCINOMA STOMACH / METS 6 M.</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <b>A.P. Nazemi M.D.</b>		29c. LICENSE NUMBER <b>D17322</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/28/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. ATAOLLAH NAZEMI M.D. 100 N. BROADWAY BALTIMORE, MD. 21231</b>															
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1122

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23567

1 - FOR  
STATE  
REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last) <i>Isaiah B. Banks</i>				2. DATE OF DEATH MONTH <i>8</i> DAY <i>27</i> YEAR <i>91</i>		3. TIME OF DEATH <i>11:30 A.M.</i>		
4. SOCIAL SECURITY NUMBER <i>213-09-2100</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>81</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>3-15-10</i>		8. BIRTHPLACE (State or Foreign Country) <i>N.J.</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Deaton Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>			9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT								
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>615 Newpittsburg</i>				10f. ZIP CODE <i>21222</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY <i>Bethlehem Steel</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Isaiah Banks</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MARY L. Chester</i>				
19a. INFORMANT'S NAME (Type/Print) <i>Elva Banks</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>615 Newpittsburg Ave. Balto. MD 21222</i>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arbutus Memorial</i>			20c. LOCATION — City or Town, State <i>Arbutus</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Vaughn C. Greene</i>				22. NAME AND ADDRESS OF FACILITY <i>James Morton FH 1701 Laurens St</i>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Prostatic carcinoma with widespread metastases.</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Besure sore</i> <i>Dementia of uncertain etiology.</i>								
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George Taler</i>				29c. LICENSE NUMBER <i>D19858</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/28/91</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>George Taler, M.D., 611 S. Charles St., Baltimore, Md., 21230</i>								
31. DATE FILED (Month, Day, Year) <i>AUG 30 1991</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>				





91-4913-015

91 23568

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN HENRY BEAMAN</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>27</b> YEAR <b>1991</b>		3. TIME OF DEATH ( <b>9:00 A M</b> )	
4. SOCIAL SECURITY NUMBER <b>216-52-5574</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/6/46</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9a. FACILITY NAME (If not institution, give street and number) <b>169 CONIWINGO ROAD</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CONIWINGO</b>		9c. COUNTY OF DEATH <b>CECIL</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Darlington</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3503 Hughes Road</b>				10f. ZIP CODE <b>21034</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		17. KIND OF BUSINESS/INDUSTRY <b>Saw Mill</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Herman Angelo Beaman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ruth Eleanor Glassman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary R. Miller</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3503 Hughes Road Darlington, MD 21034</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Yorktowne Crematory 8/29/91</b>		20c. LOCATION — City or Town, State <b>York, PA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeffrey P. Lovelady</i>				22. NAME AND ADDRESS OF FACILITY <b>Harkins Funeral Home, Inc. Delta, PA</b>			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Epilepsy</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Alcoholism</b>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>VAN</b>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Locke MD</i>				29c. LICENSE NUMBER <b>O C M E</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-28-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. LOCKE MD 111 N. PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EILEEN W. COLLINS</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>27</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>05:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-40-0708</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-15-07</b>		8. BIRTHPLACE (State or Foreign Country) <b>MAINE</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE CO.</b>		10c. CITY, TOWN OR LOCATION <b>TOWSON</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>911 DUNELLEN DRIVE</b>				10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American-Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>3</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CHURCH ORGANIST</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN WATSON</b>					18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HANNAH INGHAM</b>				
19a. INFORMANT'S NAME (Type/Print) <b>FAMILY RECORDS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ABOVE</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREENMOUNT CEM. 8/29</b>		20c. LOCATION — City or Town, State <b>BALTIMORE CITY.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>J. J. J. J. J.</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF CHIMES 2325 ROCK RD. TIMONUM</b>					
23. PART I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>restrictive lung disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Kyphoscoliosis</b> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>3 days</b> <b>1 yr</b> <b>1 yr</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>8/27/91</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Johns Hopkins Hospital</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Wm T. Moore</b>				29c. LICENSE NUMBER <b>70620</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/27/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Wm T. Moore 600 N Wolfe St. Baltimore MD 21205</b>									
31. DATE FILED (Month, Day, Year) <b>8/27 AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

DHMH-16 Rev 1/89

TO THE MEDICINE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DORIS LAVINE DASHIELD</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>25</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>841 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-76-8189</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 12 1926</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>University Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4133 Norfolk Avenue</b>			
10f. ZIP CODE <b>21216</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>9th Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>George Mundell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gertrude Matthews</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sandra L. Evans</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3111 Ravenwood Ave. Baltimore, MD 21213</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, other place) <b>King Memorial Park</b>		DATE <b>8/30</b>		20c. LOCATION — City or Town, State <b>Baltimore Co., MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ernest R. Ferry Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cerebral Edema</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Cerebral Hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James F. Narcozay, MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2250 Green St. Balt., MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>Aug 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17527 1



REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

01 63273

91 23573

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHESTER M. DUDEK</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG 28, 1991</b>		3. TIME OF DEATH <b>8:15AM</b>	
4. SOCIAL SECURITY NUMBER <b>215-09-9862</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/4/1913</b>	
8. BIRTHPLACE (State or Foreign Country) <b>BALTO., MD.</b>		9a. FACILITY NAME (If not institution, give street and number) <b>STELLA MARIS HOSPICE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON, MARYLAND</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>TOWSON</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2300 DULANEY VLLY. RD.</b>				10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WKY OR DATES <b>1942 ARMY WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b> <b>POLISH/AMER.</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9TH</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>STOCKS</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH DUDEK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JOSEPHINE PIETZIKOWSKA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>STELLA MARIS HOSPICE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2300 Dulaney Vally. RD. Towson, Md. 21204</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HOLY ROSARY CEMETARY</b>		DATE <b>8/30</b>		20c. LOCATION — City or Town, State <b>BALTO MD</b> <b>7305 GERMAN HILL RD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward J. Weber</i>				22. NAME AND ADDRESS OF FACILITY <b>EDWARD J. WEBER FUNERAL HOME BALTO MD 21231</b> <b>401 S CHESTER ST.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>8/30</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Davidson-Randall</i>				29c. LICENSE NUMBER <b>915404</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/30/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23574

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Genna Davis</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>26</b> YEAR <b>91</b>		3. TIME OF DEATH <b>507A M</b>	
4. SOCIAL SECURITY NUMBER <b>215 24 1354</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/19/13</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>University of Maryland Hosp</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto, MD</b>		9c. COUNTY OF DEATH <b>Balto</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore, MD</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>5220 York Rd</b>			
10f. ZIP CODE <b>21212</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MACHINE OPERATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>J.L. CLARK CORP.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CORNEILUS Williams</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MUSSORI RHODES</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROBIN DAVIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>855 EVESHAM AVE./BALTIMORE, MD 21212</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James A. Morton</b>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Son 1701 Laurens St.</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Dissecting Thoracic Aneurysm</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>2 wks</b>	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>Severe Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>2 wks</b>	
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD - Intern Dept of Med</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/26/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print) <b>Dept of Medicine Univ. of Md Hosp 223 Greene St Baltimore, MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>		32. REGISTRAR'S SIGNATURE <b>Jill Davidson-Rendell</b>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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ITEM:2 per FH  
G-679 9/3/91 cm

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23575

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEASED'S NAME (First, Middle, Last) <b>Stella J. D'Esposito</b>		2. DATE OF DEATH MONTH DAY YEAR <b>8-29-91</b>		3. TIME OF DEATH <b>400 p m</b>	
4. SOCIAL SECURITY NUMBER <b>212-26-5405</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62 YRS.</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>1-13-1929</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key Medical Cen.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3722 E. Lombard Street</b>		10f. ZIP CODE <b>21224</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12)</b> <b>12th</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Frederick Freidel</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Ketchum</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dominick D'Esposito</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3722 E. Lombard Street Balto. Md. 21224</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street 21224</b>			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.		Approximate Interval Between Onset and Death <b>one hour</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY <b>M</b> 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED  28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 	
29c. LICENSE NUMBER <b>16892 JTH</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/29/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Timothy M. Garrison 1714 Woodlawn St. Baltimore MD 21205</b>		31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>	
32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EVELYN ISABEL FORSHT</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>07:30 PM</b>	
4. SOCIAL SECURITY NUMBER <b>217-38-1685</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-18-11</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>	
9c. COUNTY OF DEATH <b>A.A. COUNTY</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>714 DELMAR AVE.</b>	
10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>NONE</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>		17. FATHER'S NAME (First, Middle, Last) <b>OSCAR KLING</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>KATHRYN VONADA</b>		19a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS 10</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS 10</b>		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK 8-31</b>		20c. LOCATION — City or Town, State <b>GLEN BURNIE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME</b> <b>1 SECOND AVE. S.W. GLEN BURNIE, MD 21061</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Renal Failure</b> <b>b. Congestive Heart Failure</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>c.</b> <b>d.</b>		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>8/29/91</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>034109</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8/29/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. MICHAEL SYLVA, M.D. / 1600 CRAIN HIGHWAY SW / GLEN BURNIE, MD. 21061</b>		31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1780-1800



TO THE HOSPITAL OR TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director is responsible for filing the certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 is marked, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23577

1. DECEDENT'S NAME (First, Middle, Last) Evelyn Lewis Gordon				2. DATE OF DEATH MONTH DAY YEAR Aug. 23, 1991		3. TIME OF DEATH 6:30P M					
4. SOCIAL SECURITY NUMBER 219-01-1387		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug 25 1907		8. BIRTHPLACE (State or Foreign Country) North Carolina			
9a. FACILITY NAME (If not institution, give street and number) 140 W. Lafayette Ave Golden Touch Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH				
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 1701 Eutaw Place				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? U. S. A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) Dock Lewis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clemmie Singletary							
19a. INFORMANT'S NAME (Type/Print) Delores Hobbs				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4202 Greenway Baltimore, MD 21218							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arbust Memorial Park 8/29		20c. LOCATION — City or Town, State Baltimore Co., MD		20d. DATE					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon R. Bailey				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes 2501 Gwynns Falls Parkway Baltimore, Maryland 21216							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer of Cervix Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST } b. Arteriosclerosis c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dehydration Sepsis								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Anil Uberoi MD				29c. LICENSE NUMBER D26748		29d. DATE SIGNED (Month, Day, Year) 8/27/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANIL UBEROI 3830 FALLS RD BALTO MD 21211											
31. DATE FILED (Month, Day, Year) AUG 30 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell							

11257

1728-6655

91 23578

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lillie Augustus Gaither</b>						2. DATE OF DEATH MONTH DAY YEAR <b>Aug 17, 1991</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>212-74-8774</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct 27 1900</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1513 Matthew Town Road</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Hanover</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Hanover</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10f. STREET AND NUMBER <b>1513 Matthew Town Road</b>		10g. ZIP CODE <b>21076</b>		10h. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		10i. RACE — American Indian, Black, White, etc. <b>Black</b>		10j. SPECIFY:	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		15b. KIND OF BUSINESS/INDUSTRY		16. FATHER'S NAME (First, Middle, Last) <b>Nicholas Matthews</b>		16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosie Oliver</b>		17. INFORMANT'S NAME (Type/Print) <b>Doris Brashears</b>	
17a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5352 Mad River Lane Columbia, MD 21044</b>		17b. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		17c. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Saints Rest Cemetery 8/21 Harmons, Maryland</b>		17d. DATE <b>8/21</b>		17e. LOCATION — City or Town, State <b>Harmons, Maryland</b>	
18. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Herbert E. Nutter</b>		18. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>		19. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Ischemic Cardiovascular Pathology</b>		19a. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		19b. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
20. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Organic Brain Syndrome</b>		20a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		20b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		21. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		21. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
22. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		22a. DATE OF INJURY (Month, Day, Year)		22b. TIME OF INJURY M		22c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		22d. DESCRIBE HOW INJURY OCCURRED	
22e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		22f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		23. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		23a. SIGNATURE AND TITLE OF CERTIFIER <b>John Davidson-Randall</b>		23b. LICENSE NUMBER	
23c. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)		23d. DATE SIGNED (Month, Day, Year) <b>8-21-91</b>		24. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>		24. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>		25. DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23579

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert John Gray				2. DATE OF DEATH MONTH 08 DAY 28 YEAR 91		3. TIME OF DEATH 4:55 PM	
4. SOCIAL SECURITY NUMBER 025-28-6269		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3 26 1905	
8. BIRTHPLACE (State or Foreign Country) N. IRELAND				9a. FACILITY NAME (If not institution, give street and number) CHESAPEAKE MANOR		9b. CITY, TOWN OR LOCATION OF DEATH ARNOLD	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MD		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION PASADENA				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 7874 KINGS ARM COURT	
10f. ZIP CODE 21122				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: WHITE				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 6 yrs			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEXTILE ENGINEER				16b. KIND OF BUSINESS/INDUSTRY YARN MANUFACTURER			
17. FATHER'S NAME (First, Middle, Last) ROBERT GRAY				18. MOTHER'S NAME (First, Middle, Maiden Surname) SUSAN CORKEN			
19a. INFORMANT'S NAME (Type/Print) SUSAN BERYL SEXTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7874 KINGS ARM COURT PASADENA, MD 21122			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY			
20c. DATE 8-29				20d. LOCATION — City or Town, State BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER S. MUMFORD M.D.				29c. LICENSE NUMBER D21776		29d. DATE SIGNED (Month, Day, Year) 8/28/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. MUMFORD M.D. 1600 CHAIN HWY #308 GLENBURNIE MD 21061							
31. DATE FILED (Month, Day, Year) AUG 30 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0755- 52



91 23580

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NOREEN B. HAUSE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8-30-91</b>		3. TIME OF DEATH <b>12:59 AM</b>	
4. SOCIAL SECURITY NUMBER <b>703-07-9932</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-01-03</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9. COUNTY OF DEATH <b>HARFORD</b>			
10a. STATE <b>MD</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>3501 ST. PAUL ST</b>			
10f. ZIP CODE <b>21218</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>B+O Railroad</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Henry BAYLY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY FINN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Family Record</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore National</b>		20c. LOCATION — City or Town, State <b>Baltimore City</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert W. G... ..</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS Chapel of Memories 8800 Harford Rd Balto. Md 21234</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Subarachnoid Hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Drinking Maltitis, uncontrolled</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Cerebral infarction, old.</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Dementia, etiology undetermined</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Abused Fib. irritation, chronic Congestive Heart Failure Tracheobronchitis, aspiration</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Andrew Nowakowski MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/30/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. NOWAKOWSKI MD, 125 N. MAIN ST. BEL AIR, MD 21034</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Dr. J. H. Miller, mounted  
② Verbal information, old  
Dental, etiology, mechanism

After tipillation, chronic  
infection, tooth failure  
Therapeutic, operation  
✓  
✓

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23581

1. DECEDENT'S NAME (First, Middle, Last) <b>Sarah Elizabeth Husk</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>19</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:05 AM</b>	
4. SOCIAL SECURITY NUMBER <b>21330 9538</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-16-1902</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Reeders Memorial Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Boonsboro</b>		9c. COUNTY OF DEATH <b>Washington</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>CARNEY</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9847 HARFORD ROAD</b>				10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 YRS.</b> College (1-4 or 5+) <b>AT HOME</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>AT HOME</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Joseph W. Williamson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>IDA M. VORS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FAMILY RECORDS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ABOVE</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DULANSY VALLEY MEM GAR.</b>		20c. LOCATION — City or Town, State <b>Timonium, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANGELICAL CHURCH 2325 YORK ROAD - Timonium</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>② MCA Cerebrovascular episode &amp; Aphasia and dysphagia</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>10 days</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes mellitus</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>RJ. Kuyler MD</b>				29c. LICENSE NUMBER <b>D 26579</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/19/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>100 Gentry Lane Keedysville, Md 21756</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>Jill Davidson-Randall</b>			



91 23582

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Hicken, Gertrude M.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8 27 91</b>		3. TIME OF DEATH <b>1:45 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>212-30-5761</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>98</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-15-93</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2300 Dulaney Valley Rd.</b>				10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SALES LADY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWNER</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN MARTIN PREWER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>KATHRYN MATTES</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FAMILY RECORDS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ABOVE</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEM. P/B COCKEYSVILLE, MD.</b>		20c. LOCATION — City or Town, State <b>COCKEYSVILLE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jeffrey L. Gair</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF CHIMES 2325 YORK ROAD.</b>			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Cerebral Vascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  						Approximate Interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Eddie Nakhuda</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>Jeha Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN-MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The signatures that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SPR 10



91 23583

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY JANE HOLSOPPLE</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>21</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:32 A</b>	
4. SOCIAL SECURITY NUMBER <b>033 20 0723</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10 18 30</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		8c. BIRTHPLACE (State or Foreign Country) <b>MASSACHUSETTS</b>	
RESIDENCE OF DECEDENT				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE - PERRY HALL</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4007-C MARJEFF PLACE</b>				10f. ZIP CODE <b>21236</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+) <b>AT Home</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>AT Home</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>GOODELY SHERMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY JANE BANKS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FAMILY RECORDS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ABOVE</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CEMETERY</b>		20c. LOCATION — City or Town, State <b>BALTO. MD.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HYPOXEMIA</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>TRACHEAL OBSTRUCTION</b>							
c. <b>LARGE CELL UNDIFFERENTIATED CARCINOMA OF LUNG</b>							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] M.D.</b>				29c. LICENSE NUMBER <b>D25010</b>		29d. DATE SIGNED (Month, Day, Year) <b>8 21 91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G.B.M.C. 6701 N CHARLES ST</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23584

1. DECEDENT'S NAME (First, Middle, Last) Corrine Hines				2. DATE OF DEATH MONTH 8 DAY 27 YEAR 1991		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 129-22-1660		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5-21-17		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) 1916 W. North Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT											
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1916 W. NORTH AVENUE				10f. ZIP CODE 21217		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) RAMOND RAMSEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) DELIA STEPHANS							
19a. INFORMANT'S NAME (Type/Print) ANNIE MAE BOLDS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1916 W. NORTH AVE./BALTIMORE, MD 21217							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) KING MEMORIAL PARK CEM.		20c. LOCATION — City or Town, State RANDALLSTOWN, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys Wane				22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVE.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC BREAST CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Meningeal								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]						29c. LICENSE NUMBER D30405		29d. DATE SIGNED (Month, Day, Year) [Signature]			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lillian V. Johnson RUD #302											
31. DATE FILED (Month, Day, Year) AUG 30 1991				32. REGISTRAR'S SIGNATURE J. Davidson-Rendell							

10500000

91 23585

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHRISTOPHER A. HOPE</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:20 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-90-5660</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>21</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 29, 1969</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>OLD ANNAPOLIS RD. (ROADWAY)</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ELLICOTT CITY</b>		9c. COUNTY OF DEATH <b>HOWARD</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>HOWARD</b>		10c. CITY, TOWN OR LOCATION <b>COLUMBIA</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>9002 WETBANKS COURT</b>				10f. ZIP CODE <b>21045</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>1</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MERCHANT SEAMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SHIPPING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>BRIAN H. HOPE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BARBARA J. LOZIER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BRIAN H. HOPE (FATHER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9002 WETBANKS COURT, COLUMBIA, MARYLAND 21045</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>ST. JOHN'S CEMETERY 9/31/91</b>		20c. LOCATION — City or Town, State <b>ELLICOTT CITY, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy M. Witzke</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Injuries</b> Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Due to (or as a consequence of): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b>					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>8 28 91</b>		28b. TIME OF INJURY <b>7:10 A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>PASSENGER AUTO-AUTO IMPACT</b>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>OLD ANNAPOLIS RD.</b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>OLD ANNAPOLIS RD. ELLICOTT CITY, MD.</b>							
29a. CERTIFIER (Check only) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Laron Locke M.D.</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUGUST 28, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. LARON LOCKE M.D. 111 PENN ST. BALTIMORE, MD. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2020-10-10

10/10/2020

91 23586

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>HARRY LEONARD JUDMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8-27-91</b>		3. TIME OF DEATH <b>9:20 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>213-14-3135</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/25/1917</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2520 FARRINGTON RD.</b>	
10f. ZIP CODE <b>21209</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>			
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OWNER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>PAWN SHOP</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ISAAC JUDMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DORA SELENKOW</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. MIRIAM CLARA JUDMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2520 FARRINGTON RD. BALTIMORE, MD 21209</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SHAAREI ZION 8/29/91</b>		20c. LOCATION — City or Town, State <b>ROSEDALE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Stillman</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
23. PART II. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Artery Disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>2 other HT - Disease</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>ASCD</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> POA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>1-04601</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/27/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1777 REISTERSTOWN RD - BALTO - MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1-2-8 12

91 23587

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edward Adam Kowalewski</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Aug. 29 1991</b>		3. TIME OF DEATH <b>8:25 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-09-2989</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 21 1904</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9b. COUNTY OF DEATH <b>Baltimore</b>	
9c. RESIDENCE OF DECEDENT (If not institution, give street and number) <b>St. Joseph's Hospital</b>							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>601 Horncrest Road</b>				10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chief Engr.-Beth.Steel</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel Manufacturing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Anthony Kowaleswski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Stella Kurowski</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Catherine E. Kowalewski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>601 Horncrest Rd., Towson, Md. 21204</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Stanislaus Cemetery</b>		20c. LOCATION — City or Town, State <b>Dundalk, Maryland</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lowell M. Lemmon</i> <b>Lowell M. Lemmon</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld</b> <b>10 W. Padonia Rd., Timonium, Md. 21093</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Stromberg MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/29/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Mark Stromberg 7505 Osler Rd. Suite 410</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 23588			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR 08 27 91				3. TIME OF DEATH 6:00 A.M.			
4. SOCIAL SECURITY NUMBER 219-26-1861				5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (in yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03-07-15		8. BIRTHPLACE (State or Foreign Country) Kentucky	
9a. FACILITY NAME (If not institution, give street and number) CHURCH HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH -----			
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1903 Dundalk Avenue				10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3rd -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		16b. KIND OF BUSINESS/INDUSTRY Pat Block					
17. FATHER'S NAME (First, Middle, Last) John Lee Kinney				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
19a. INFORMANT'S NAME (Type/Print) Georgie Mae Kinney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1903 Dundalk Avenue Balto. Md. 21222							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cem. Comp. 8/30/91 Balto. Maryland		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph N. Zannino Jr.</i>				22. NAME AND ADDRESS OF FACILITY Joseph N. Zannino Jr. Funeral Home 263 South Conkling St. 21224							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARRHYTHMIA</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>RESPIRATORY FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David O. Nyantam</i> DAVID O. NYANTAM				29c. LICENSE NUMBER D 36974		29d. DATE SIGNED (Month, Day, Year) 8/27/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID O NYANTAM MD. 100N BROADWAY BALTIMORE MD 21231											
31. DATE FILED (Month, Day, Year) AUG 30 1991				32. REGISTRAR'S SIGNATURE <i>Judith Davidson-Randall</i>							

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HAROLD W. LETTS, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG. 27, 1991</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>214-20-2742</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 11, 1927</b>	
8. BIRTHPLACE (State or Foreign Country) <b>BALTO. MD.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3408 LAMBROS RD.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>PARKVILLE</b>	
9c. COUNTY OF DEATH <b>BALTO. CO.</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>BALTIMORE CO</b>				10c. CITY, TOWN OR LOCATION <b>PARKVILLE</b>			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>3408 LAMBROS RD.</b>			
10f. ZIP CODE <b>21234</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>CAPTAIN BALTO. CITY FIRE DEPT.</b>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			
17. FATHER'S NAME (First, Middle, Last) <b>HAROLD WARREN LETTS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LAURA M. ABBEY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FAMILY RECORDS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ABOVE</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARKWOOD CEM.</b>		20c. LOCATION — City or Town, State <b>8/30 PARKVILLE, MD.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jeffrey J. Gair</b>	
22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF MEMORIES</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Myeloma</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Davis Hahn</b>				29c. LICENSE NUMBER <b>D20394</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUG. 29, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. DAVIS HAHN GOOD SAMARITAN PROF. BUILDING</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Raymond E. Lippy-Sr.				2. DATE OF DEATH MONTH 8 DAY 28 YEAR 91		3. TIME OF DEATH 1058 A M	
4. SOCIAL SECURITY NUMBER 214-03-0743		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH (Month, Day, Year) 08 10 08	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	
9c. COUNTY OF DEATH							
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3308 ELM AVENUE				10f. ZIP CODE 21211		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) EDWARD C. LIPPY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MERYL BAUBLITZ			
19a. INFORMANT'S NAME (Type/Print) NORMA JONES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2604 CUB HILL ROAD, BALTIMORE, MARYLAND 21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY 8/31/91		20c. LOCATION — City or Town, State GLEN BURNIE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>A. Alan Seitz, Jr.</i>				22. NAME AND ADDRESS OF FACILITY A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTO., MD. 21211			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): AS CVD DUE TO (OR AS A CONSEQUENCE OF): HTN DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Pancreatic Cancer						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	
		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>D. J. Dow MD</i>				29c. LICENSE NUMBER D37133		29d. DATE SIGNED (Month, Day, Year) 8/28/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donna L. Dow MD							
31. DATE FILED (Month, Day, Year) AUG 30 1991				32. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23591

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES J. LIPPA</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 28 1991</b>		3. TIME OF DEATH <b>6:21 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-12-2996</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 24, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>5 NORTH PORT STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>-----</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>5 North Port Street</b>	
10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>-----</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Employee</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Brewery</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James F. Lippa</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherina M. Svehla</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kathryn Palczynski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3505 Mt. Pleasant Avenue Balto. Md. 21224</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Mem. Garden 8-29-90 Balto. Md.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street 21224</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (First disease or condition resulting in death) <b>ARTERIOSCLEROTIC CORONARY VASCULAR DISEASE</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>Inquiry</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFY (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 29 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kathryn P. Lippa 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 23592							
1. DECEDENT'S NAME (First, Middle, Last)				E. MORRIS				2. DATE OF DEATH				3. TIME OF DEATH			
ALBERTA								8 26 1991				9:20 A M			
4. SOCIAL SECURITY NUMBER				5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)					
213 28 8440				1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		58 YRS.		2/8/33		Md.					
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH							
1510 MOSHER STREET				BALTIMORE											
10a. STATE				10b. COUNTY				10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
Md.								Balto.				<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?							
1510 W. Mosher St.				21217				U.S.A.							
11. MARITAL STATUS				12. WAS DECEDENT EVER IN U.S. ARMED FORCES?				13. WAS DECEDENT OF HISPANIC ORIGIN?				14. RACE — American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12)				College (1-4 or 5 +)				Housewife							
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)											
Clifton Morris				Ethel Young											
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Deborah Belin				1513 W. Mosher St. Balto., Md. 21217											
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State							
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				King Memorial Park 8/31 Balto., Md.											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY											
James A. Morton				James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate interval between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →				a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>											
				b. DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				c. DUE TO (OR AS A CONSEQUENCE OF):											
				d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO INQUIRY				1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)											
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE NOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)				29b. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)							
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				O C M E				8-27-1991							
29c. SIGNATURE AND TITLE OF CERTIFIER															
Mortimer D. Morton															
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
MORTIMER D. MORTON 111 N. PENN STREET BALTIMORE, MARYLAND 2120															
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE											
AUG 30 1991				Lillian Davidson-Randall											

SECRET

91 23593

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNE THERESA WALLACE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 28, 1991</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>323-03-3895</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-30-1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>ILLINOIS</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Dundalk</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2602 Lynbrook Road</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PERSONNEL WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CORP OF ENGINEERS</b>			
17. FATHER'S NAME (First, Middle, Last) <b>FRANK KACZMAREK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SOPHIE SOWIA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Lloyd Wallace</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2602 Lynbrook Road Dundalk, Md. 21222</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SACRED HEART OF JESUS CEM. 8-31-91 BALTIMORE, MARYLAND</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Md. 21222</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Metastatic breast CA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>5 days</b> <b>1 year</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>lung metastases</b>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>MD33627</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/28/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23594

1. DECEDENT'S NAME (First, Middle, Last) <b>James Rell Parsons</b>				2. DATE OF DEATH August 29 1991 YEAR MONTH DAY				3. TIME OF DEATH 11:30 AM					
4. SOCIAL SECURITY NUMBER <b>245 10 7375</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH May 7, 1914		8. BIRTHPLACE (State or Foreign Country) <b>N.C.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Ivy Hall Geriatric Center</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Middle River</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>White Marsh</b>						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>11142 Red Lion Rd.</b>						10f. ZIP CODE <b>21162</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Pile Driver</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Marine Construction</b>					
17. FATHER'S NAME (First, Middle, Last) <b>William Thurman Parsons</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude Belle Bishop</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Shelby Jean Kruse, Daughter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11 Stabilizer Dr. Baltimore, Md. 21220</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Memorial Gardens</b>				DATE <b>8/31/91</b>		20c. LOCATION — City or Town, State <b>Baltimore Co., Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>						22. NAME AND ADDRESS OF FACILITY <b>Bruzdinski Funeral Home PA</b> <b>1407 Eastern Ave. Balto., Md. 21221</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARREST</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  Due to (or as a consequence of):  Approximate Interval Between Onset and Death													
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Belian E. Parra M.D.</i>						29c. LICENSE NUMBER <b>002966</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-30-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>3007 E. NORTHERN PKWY. 21214</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									



ITEMS:23,27 per ME  
G-679 9/27/91 cm

91-4886-510

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23595

1. DECEDENT'S NAME (First, Middle, Last) <b>James Denard Powell</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 26 1991</b>		3. TIME OF DEATH <b>11:35 AM</b>							
4. SOCIAL SECURITY NUMBER <b>216-74-3867</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>26</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr 26 1965</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>5907 LaCleda Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH					
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>5907 LaCleda Road</b>				10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th Grade</b> College (1-4 or 5+) <b>Unemployed</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>Clarence E. Powell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carol A. Suggs</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Carol A. Powell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5907 LaCleda Road Baltimore, MD 21206</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore Cemetery 8/31</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sam R. Ferry Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. FOCAL MYOCARDITIS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Steven J. Chute MD</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 27 1991</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 Penn Street, Baltimore Maryland 21201</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23596

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANGELINA PROTANI</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 30, 1991</b>		3. TIME OF DEATH <b>6:49 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>220073353</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02/15/23</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
9b. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOSPITAL CORPORATION</b>				10a. STATE <b>MD.</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>5513 Todd Avenue</b>	
10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Tailoring</b>		16. KIND OF BUSINESS/INDUSTRY <b>Hess Tailoring</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Tailoring</b>		16. KIND OF BUSINESS/INDUSTRY <b>Hess Tailoring</b>		17. FATHER'S NAME (First, Middle, Last) <b>Vincenzo Protani</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Vincenzo Protani</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Assunta Mastracci</b>		19a. INFORMANT'S NAME (Type/Print) <b>Anthony F. Rinaldi</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4221 Winterode Way Perry Hall, MD 21236</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Martin J. Duppel Jr.</b>	
22. NAME AND ADDRESS OF FACILITY <b>Dippel Funeral Home, Inc.</b>		22. NAME AND ADDRESS OF FACILITY <b>7110 Belair Road Baltimore, MD. 21206</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>A. respiratory failure</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. suspected lung cancer</b> <b>c. CHF florid pneumonia</b>		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mukesh Luhar</b>		29c. LICENSE NUMBER <b>D24303</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8/30/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHURCH HOSPITAL CORPORATION</b> <b>DR. MUKESH LUHAR, M.D.</b> <b>100 N BROADWAY BALTIMORE, MD. 21231</b>		31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>		32. REGISTRAR'S SIGNATURE <b>Sha Davidson</b>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH					
Katherine I Ramsey				08 28 91				2:00 p.m.					
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
218-14-9836		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	71 YRS.					01/26/20		Maryland			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH					
Greater Baltimore Medical Center				Towson				Baltimore					
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
MD		Baltimore		Baltimore									
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
9823 Homeland Road				21234				U.S.A.					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:									
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4				HOMEMAKER									
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)							
CARL SENNHENN						MARGARET							
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
FAMILY RECORDS						SAME AS ABOVE							
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State					
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				GREENMOUNT CEM. 429				BALTO. CITY, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE						22. NAME AND ADDRESS OF FACILITY							
Judy L. Gair						EVANS CHAPEL OF MEMORIES							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ovarian Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Renal Failure DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Bowel Obstruction										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER G A M D						29c. LICENSE NUMBER 027730		29d. DATE SIGNED (Month, Day, Year) 8/29/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gary Cohen, M.D.													
31. DATE FILED (Month, Day, Year) AUG 30 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

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**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

91 23598

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RUSSELL E. ROYALL, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 27 91</b>		3. TIME OF DEATH <b>5:46 P<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>217 86 9929</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>22</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 14 1969</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not institution, give street and number) <b>ROUTE 40 in EDGEWOOD</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>EDGEWOOD</b>				11. COUNTY OF DEATH <b>HARFORD</b>			
12a. STATE <b>Md.</b>		12b. COUNTY <b>Harford</b>		12c. CITY, TOWN OR LOCATION <b>Joppa</b>		12d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13a. STREET AND NUMBER <b>914 Pulaski Hiway</b>				13b. ZIP CODE <b>21085</b>		13c. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		15. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES		16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		17. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
18. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>				19. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Plant Operator</b>		20. KIND OF BUSINESS/INDUSTRY <b>Sand Co.</b>	
21. FATHER'S NAME (First, Middle, Last) <b>Russell E. Royall, Sr.</b>				22. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Linda Bevans</b>			
23. INFORMANT'S NAME (Type/Print) <b>Russell E. Royal, Sr.</b>				24. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>914 Pulaski Hiway Joppa, Md. 21085</b>			
25a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		25b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Memorial Gardens 8/30/91</b>		25c. LOCATION — City or Town, State <b>Baltimore Co., Md.</b>		26. NAME AND ADDRESS OF FACILITY <b>Bruzdzinski Funeral Home PA 1407 Eastern Ave. Baltimore, Md. 21221</b>	
27. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				28. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple injuries</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  29a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
29. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		30. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b>					
31. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		32a. DATE OF INJURY (Month, Day, Year) <b>08/27/91</b>		32b. TIME OF INJURY <b>5:46 P<sup>M</sup></b>		32c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
33. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Roadway</b>				34. DESCRIBE HOW INJURY OCCURRED <b>Motorcycle struck auto</b>			
35. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>ROUTE 40</b>				36. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
37. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				38. LICENSE NUMBER <b>O.C.M.E.</b>		39. DATE SIGNED (Month, Day, Year) <b>08/28/91</b>	
40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J-LAWSON Locke MD 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
41. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>		42. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23599

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN RICHTER</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>29</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:00 am</b>	
4. SOCIAL SECURITY NUMBER <b>215-03-6069</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-2-11</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1448 DECATUR STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE, MD</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MD</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1448 DECATUR STREET</b>	
10f. ZIP CODE <b>21230</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>PIPE FITTER</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>FELIX RICHTER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA GLAVE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY L. RICHTER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1448 DECATUR STREET BALTO., MD 21230</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GLEN HAVEN CEMETERY</b>		20c. DATE <b>8/31</b>		20d. LOCATION — City or Town, State <b>GLEN BURNIE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. Shiley Dale</i>				22. NAME AND ADDRESS OF FACILITY <b>CHARLES L. STEVENS FUNERAL HOME, INC. 1501 E. FORT AVE. BALTIMORE, MD 21230</b>			
23. PART I. Enter the diseases, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA LUNG</b> Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>HOSPICE</b>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Attorney MD</i>				29c. LICENSE NUMBER <b>021776</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/30/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SURYA P. MUNDRA MD 203 E. Potomac Ave. Baltimore MD 21225</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02262 10



ITEMS:23 thru 28f per ME  
G-679 9/20/91 cm  
91-4916-510

91 23600

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>CAROLYN</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>27</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>2:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-54-3741</b>		5. SEX <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>40</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-15-1951</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOME AND HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
10e. STREET AND NUMBER <b>1313 Valley St.</b>				10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</b> <b>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:</b>				14. RACE — American Indian, Black, White, etc. Specify: <b>black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 th</b> <b>College (1-4 or 5 +)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Hairdresser</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Cosmetology</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Clark</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Hazel Richardson</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Teresa Jennings</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5512 Pilgrim Rd. Balto., Md. 21214</b>					
20a. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b> <b>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star Cemetery 9-3</b>		20c. LOCATION — City or Town, State <b>Catonsville Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph R. Walters</i>				22. NAME AND ADDRESS OF FACILITY <b>Derrick C. Jones F.H.</b> <b>4611 Park Heights Ave. Balto., Md. 15</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. NARCOTIC INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> OTHER: <b>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>				27. MANNER OF DEATH <b>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b> <b>5 <input checked="" type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined</b>				28. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>	
29a. CERTIFIER (Check only one) <b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Carolanne MD</i>				29c. LICENSE NUMBER <b>O C M E</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8-28-1991</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 N. PENN STREET BALTIMORE, MARYLAND 21201</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If number is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LOUIS THEODORE STAMM</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>07 35 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213 01 1386</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/10/1916</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>TOWSON</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>107 KENILWORTH DRIVE</b>				10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, other Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SELF EMP.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SUN PAPER DIST.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>LOUIS T. STAMM, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROBERTA A. CROSS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FAMILY RECORDS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ABOVE</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GRACERSON FOREST 9/3</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>J. J. J. J. J.</b>				22. NAME AND ADDRESS OF FACILITY <b>EVANS CHAPEL OF CHIMES TIMOTHY, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA/CHF</b> Approximate Interval Between Onset and Death a. DUE TO (OR AS A CONSEQUENCE OF): <b>Pneumonia</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>CHF</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>H18792</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained for hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1995-1996



91 23602

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARIE LAURA SMITH				2. DATE OF DEATH MONTH DAY YEAR 8 27 91		3. TIME OF DEATH 9:30 AM	
4. SOCIAL SECURITY NUMBER 217-05-5316		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS 27 26 18		7. DATE OF BIRTH (Month, Day, Year) 02-26-18	
8. BIRTHPLACE (State or Foreign Country) NEW YORK				9. COUNTY OF DEATH BALTIMORE			
10. FACILITY NAME (If not institution, give street and number) DEATON HOSPITAL				11. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			
10a. STATE MD.		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION DUNDALK		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7008 Mornington Rd. Apt. C				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Ralph Barresi				18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine D'Ambra			
19a. INFORMANT'S NAME (Type/Print) Franklin Adams				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7008 Mornington Rd., Apt. C, Dundalk, MD. 21222			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory		20c. LOCATION — City or Town, State Balto., Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, INC. 2134 Willow Spring Rd., Dundalk, Md. 21222					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 YEAR
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 027394		29d. DATE SIGNED (Month, Day, Year) 8/27/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James P. Richardson MD 611 S. CHARLES ST. BALTO MD 21230							
31. DATE FILED (Month, Day, Year) AUG 30 1991		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23603

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Helen Lucille Stafford				2. DATE OF DEATH MONTH 8- DAY 29- YEAR 1991				3. TIME OF DEATH A M	
4. SOCIAL SECURITY NUMBER 217-03-9958		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 9-21-1911		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) 7404 Linwood Ave.				9b. CITY, TOWN OR LOCATION OF DEATH Edgemere				9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Edgemere-				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7404 Linwood Ave.				10f. ZIP CODE 21219		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Rest/Food		16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel			
17. FATHER'S NAME (First, Middle, Last) Thomas Norris Stafford				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Bertha Day					
19a. INFORMANT'S NAME (Type/Print) Norma J. Robertson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7404 Linwood Ave., Balto., Md. 21219					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 8-31-91		20c. LOCATION — City or Town, State Balto. Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert S. Ashten</i>				22. NAME AND ADDRESS OF FACILITY Moran-Ashton Funeral Home, Inc. 3000 E. Baltimore St., Balto. Md. 21224					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>pulmonary Fibrosis</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CHF</i>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>ME Thomas</i>				29c. LICENSE NUMBER D20673		29d. DATE SIGNED (Month, Day, Year) 8/30/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5810 Belgia Rd 21206									
31. DATE FILED (Month, Day, Year) AUG 30 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 20 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00703 43



91 23604

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Eva T. Studzinski</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>30</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:00 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-07-5877</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>98</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/1/1893</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOME HOSP</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>PA</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10 S. Highland Avenue</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cook</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Catering</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Stanley Pietrowicz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Josephine Skowronska</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Joan Studzinski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3311 Leverton Avenue Balto 21224</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Rosary Cemetery 9/3 Balto County</b>		20c. LOCATION — City or Town, State		22. NAME AND ADDRESS OF FACILITY <b>Moran-Ashton Funeral Home 3000 E/ Baltimore St. Balto 21224</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Moran-Ashton Funeral Home 3000 E/ Baltimore St. Balto 21224</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ischemic Bowel d/s.</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>Atherosclerotic disease</b>							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rajesh Chawla no. House staff</b>				29c. LICENSE NUMBER <b>D41097</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/30/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RAJESH CHAWLA CHURCH HOSPITAL</b>							
31. DATE OF DEATH (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91-4876-005

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 23605

1. DECEDENT'S NAME (First, Middle, Last) <b>Thelma Delores Scott Evans</b>						2. DATE OF DEATH MONTH DAY YEAR <b>08 25 1991</b>		3. TIME OF DEATH <b>11:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-46-8743</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept 26 1948</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Joseph's Hospital</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>1701 East North Ave.</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Youth Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Charles H. Hickey Sch</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Leon Scott, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Inez Batts</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Jimmie Evans, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1701 East North Ave Apt 211 Balto. MD 21213</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		DATE <b>8/30</b>		20c. LOCATION — City or Town, State <b>Baltimore Co., MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ATHROSCLECTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 26 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARYANN D. WORTH 111 Penn Street, Baltimore Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-01



91-4851-510

91 23606

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Frank J. Sewell</b>						2. DATE OF DEATH MONTH DAY YEAR <b>08 23 1991</b>		3. TIME OF DEATH AM PM <b>9:27 AM</b>	
4. SOCIAL SECURITY NUMBER <b>217-01-2458</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr 5, 1913</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>814 McKean Avenue</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>814 McKean Avenue</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Postal Service</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Sewell</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Barnes</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary A. Harris</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Thornhurst Court Baltimore, MD 21207</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery 8/28 Baltimore, Maryland</b>		DATE		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Vernon R. Bailey</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>Inquiry</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 23 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Mario F. Golle, Jr. MD 111 Penn Street, Baltimore Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00000 12

ITEM:1 per FH  
G-679 9/24/91 cm

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 23607

1. DECEDENT'S NAME (First, Middle, Last) EDWARD KENNETH SHELTON KENNETH E. SHELTON				2. DATE OF DEATH MONTH DAY YEAR AUGUST 29 1991		3. TIME OF DEATH 5:30 A. M			
4. SOCIAL SECURITY NUMBER 226-34-6167		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		7. DATE OF BIRTH (Month, Day, Year) AUG. 8, 1927		8. BIRTHPLACE (State or Foreign Country) VIRGINIA	
9a. FACILITY NAME (If not institution, give street and number) SUMMIT NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE			9c. COUNTY OF DEATH BALTIMORE		
10a. STATE VIRGINIA			10b. COUNTY CHESTERFIELD		10c. CITY, TOWN OR LOCATION CHESTER			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4617 BRUCE ROAD				10f. ZIP CODE 23831		10g. CITIZEN OF WHAT COUNTRY? U. S. A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR DR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHIEF ENGINEER ANNOUNCER			16b. KIND OF BUSINESS/INDUSTRY RADIO			
17. FATHER'S NAME (First, Middle, Last) F. EDWARD SHELTON				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELSIE HILL					
19a. INFORMANT'S NAME (Type/Print) NANCY R. SHELTON (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 139 HIGHLAND WOODS WADESBORO, NORTH CAROLINA 28170					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORVEN CEMETERY 9/3/91		20c. LOCATION — City or Town, State MORVEN, NORTH CAROLINA					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy M. Witzke</i>				22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228					
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia (Bilateral)</i> <i>Perkin's Schism</i> Approximate Interval Between Onset and Death <i>Months</i> <i>35 years</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William E. McGrath M.D.</i>				29c. LICENSE NUMBER D 7777		29d. DATE SIGNED (Month, Day, Year) 9/29/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM E. McGRATH M.D. 1303 FREDERICK ROAD, BALTIMORE, MARYLAND 21228									
31. DATE FILED (Month, Day, Year) AUG 30 1991		32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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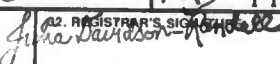


91-4928-510

91 23608

1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALVIN ELDON SHIFFLETT</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>28</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>7:22 A M</b>	
4. SOCIAL SECURITY NUMBER <b>227-34-7585</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-13-1932</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FRANCIS SCOTT KEY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>DUNDALK</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <b>205 ASHWOOD ROAD</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH GRADE</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>FURNACE MAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BETHLEHEM STEEL CORP</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH SHIFFLETT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZA SHIFFLETT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DORIS M. SHIFFLETT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>205 ASHWOOD ROAD BALTIMORE, MARYLAND 21222</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HOLLY HILL MEMORIAL 8-31-1991</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O C M E</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-28-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. L. LARSON MD 111 N. PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2020-01-01



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23609

1. DECEDENT'S NAME (First, Middle, Last) <b>Rebecca Silbert</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:02 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-07-0602-A</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>10/12/16</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>		9. COUNTY OF DEATH <b>BALTO.</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2903 FALLSTAFF RD., APT. 403</b>		10f. ZIP CODE <b>21209</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>		17. FATHER'S NAME (First, Middle, Last) <b>HYMAN MERKER</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FANNIE ROSENSTEIN</b>		19a. INFORMANT'S NAME (Type/Print) <b>MRS. HARRIET DACKMAN</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8200 TALL CHIMNEY CT. BALTIMORE, MD 21208</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHIZUK AMUNO (ARLINGTON) 8/29/91 BALTIMORE, MD</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jay Alan Lewis</b>		22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ruseberg</b>		29c. LICENSE NUMBER <b>D40851</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8/28/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ruseberg</b>		31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>	
32. REGISTRAR'S SIGNATURE <b>Jane Davidson-Randall</b>					

90288 12

91 23610

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CHAROLETTE SUSAN THOMAS				2. DATE OF DEATH MONTH DAY YEAR 08 27 1991		3. TIME OF DEATH 5:30 P M	
4. SOCIAL SECURITY NUMBER 494-12-6712		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11 13 1921	
8. BIRTHPLACE (State or Foreign Country) OKLAHOMA				9a. FACILITY NAME (If not institution, give street and number) ANNE ARUNDEL GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS	
9c. COUNTY OF DEATH ANNE ARUNDEL				10a. STATE MD		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION CROFTON				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 1675 WILKSHIRE DRIVE	
10f. ZIP CODE 21114				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 12 College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EXECUTIVE SECRETARY		16b. KIND OF BUSINESS/INDUSTRY BOWIE RACE COURSE	
17. FATHER'S NAME (First, Middle, Last) WILLIAM RILEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) PEARL GLOVER			
19a. INFORMANT'S NAME (Type/Print) RILEY WHEELER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1714 Waldorf Ct. Crofton, MD 21114			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 8-30		20c. LOCATION — City or Town, State Elkridge, MD 21227	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive Lung Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Robert T Peterson MD				29c. LICENSE NUMBER 024809		29d. DATE SIGNED (Month, Day, Year) 8-28-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert T Peterson MD 600 Ridgely Avenue Annapolis MD							
31. DATE FILED (Month, Day, Year) AUG 30 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MELVIN HENRY THIEL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 27 1991</b>				3. TIME OF DEATH <b>2000 M</b>					
4. SOCIAL SECURITY NUMBER <b>212-20-2067</b>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-3-25</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>			
RESIDENCE OF DECEDENT													
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>WORCESTER</b>				10c. CITY, TOWN OR LOCATION <b>OCEAN CITY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>321-A GORMAN AVE.</b>						10f. ZIP CODE <b>21842</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11 YRS.</b> College (1-4 or 5+) <b>NONE</b>						16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MANAGER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>BOWLING CHAIN</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HENRY PETER THIEL</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MYRTLE BUDINTAIN</b>							
19a. INFORMANT'S NAME (Type/Print) <b>GRACE JOSEPHINE THIEL</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>321-A GORMAN AVE. OCEAN CITY, MD 21842</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>ENTOMBMENT</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park 8-31</b>				20c. LOCATION — City or Town, State <b>ELKBRIDGE, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME</b> <b>1 SECOND AVE. S.W. GLEN BURNIE, MD 21061</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Malignant Lymphoma</b>													
DUE TO (OR AS A CONSEQUENCE OF):													
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER <b>026278</b>				29d. DATE SIGNED (Month, Day, Year) <b>8/28/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>David E. Carroll MD 145 E. Carroll St. Salisbury, MD 21801</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE 									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KEVIN THOMPSON</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>29</b> YEAR <b>91</b>				3. TIME OF DEATH <b>5:46A</b>		
4. SOCIAL SECURITY NUMBER <b>216-66-8373</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06 10 54</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>N/A</b>		
RESIDENCE OF DECEDENT										
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>706 Cedarcroft Road</b>				10f. ZIP CODE <b>21212</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b> College (14 or 5+) <b>4 +</b>			18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Project Manager</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Commercial Reality</b>				
17. FATHER'S NAME (First, Middle, Last) <b>William C. Thompson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Louise Dolan</b>						
19a. INFORMANT'S NAME (Type/Print) <b>William C. Thompson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8410 Loch Raven Blvd. Balto., MD 21204</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garden Dulaney Valley Mem.</b>		DATE <b>8/31</b>		20c. LOCATION — City or Town, State <b>Cockeysville, MD</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Cori L. Ebaugh</b>				22. NAME AND ADDRESS OF FACILITY <b>Johnson Funeral Home Balto., MD 8521 Loch Raven Blvd. 21204</b>						
23. PART I. Enter the diseases, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Cardiomyopathy</b>  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rajad MD</b>			29c. LICENSE NUMBER <b>2414</b>		29d. DATE SIGNED (Month, Day, Year) <b>08-29-91</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RAJAT SOOD MD SINAI HOSPITAL</b>										
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>			32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, on item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JIMMY DAVID VAIN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8 23 91</b>		3. TIME OF DEATH <b>2200</b> M	
4. SOCIAL SECURITY NUMBER <b>218-34-0445</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 18, 1939</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>927 Garden Drive Apt. 2A</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Essex</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Essex</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>927 Garden Drive Apt. 2A</b>	
10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Board of Education</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Balto. Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Henry Vain</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Stephanie Barabasz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David Vain</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1657 S. Woodbury Springfield Mo. 65809</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Connelly Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home 300 Mace Ave. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic emphysema</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. C. Rossan O'Donovan, M.D.</b>				29c. LICENSE NUMBER <b>DO 7632</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-26-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. C. ROSSAN O'DONOVAN, 2112 DUNDALK AVE., BALTO., MD. 21222</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>W. Davidson-Rendall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or funeral home. Page 5 should be detached for use as an affidavit of death permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23614

1. DECEDENT'S NAME (First, Middle, Last) <b>Augustine M. Waters</b>				2. DATE OF DEATH MONTH <b>8</b> - DAY <b>25</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>4:17 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>212166452</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/18/20</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Univ. of Maryland med. center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore city</b>		9c. COUNTY OF DEATH <b>MD</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore city</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1708 Carswell St</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LAUNDRY WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN WHITING</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LESLIE UMPREY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DOROTHY WHITING</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1708 CARSWELL ST./BALTIMORE, MD 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>BALTIMORE CEMETERY</b>		DATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys Wane</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. hypoxia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Pseudomonas otitis media / osteomyelitis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. End stage renal disease</b> DUE TO (OR AS A CONSEQUENCE OF):  d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Julia Davidson-Randell MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S. Lanzetta Univ of Maryland MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randell</b>			

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LUE BERTIE WILLIAMS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 27 1991</b>		3. TIME OF DEATH <b>2040</b> M	
4. SOCIAL SECURITY NUMBER <b>262-07-5304</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03 20 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>SEVERN</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7909 POPLAR GROVE ROAD</b>				10f. ZIP CODE <b>21144</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>NONE</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COMPUTER OPERATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>THOMPSON AND COMPANY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JESSIE C. MADDOX</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DESTIE M. HURSTON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>STEVE R. WILLIAMS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7909 POPLAR GROVE RD. SEVERN, MD 21144</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARDEN OF MEMORIES</b>		DATE <b>TAMPA, FLORIDA</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Henry Haskins</i>				22. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration Pneumonia - hypoxemia</b> Due to (or as a consequence of): a. <b>multi-infarct Dementia</b> Due to (or as a consequence of): b. <b>Hypertension</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hype Non-Insulin Dependent Diabetes mellitus</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John P. Serlento, MD</i>				29c. LICENSE NUMBER <b>D32654</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/28/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John P. Serlento, MD 180 Admiral Cochrane Dr., Crownsville, MD 21031</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>		32. REGISTRAR'S SIGNATURE <i>John P. Serlento</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO

1. DECEDENT'S NAME (First, Middle, Last) <b>WILBUR C. CLYDEN WADE, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 28 91</b>		3. TIME OF DEATH <b>06:42 PM</b>	
4. SOCIAL SECURITY NUMBER <b>216-16-6292</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11 23 1923</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9. COUNTY OF DEATH <b>A.A. COUNTY</b>			
10. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				11. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>			
12. RESIDENCE OF DECEDENT <b>MD ANNE ARUNDEL</b>				13. CITY, TOWN OR LOCATION <b>ODENTON</b>			
14. STREET AND NUMBER <b>439 HARDING AVE.</b>				15. ZIP CODE <b>21113</b>		16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
17. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				18. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			
19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				20. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>11</b> College (1-4 or 5+) <b>NONE</b>				22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CHIEF OF PLANT PROTECTION</b>			
23. KIND OF BUSINESS/INDUSTRY <b>WESTINGHOUSE</b>				24. FATHER'S NAME (First, Middle, Last) <b>WILBUR C. CLYDEN WADE SR.</b>			
25. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MILDRED E. CLARK</b>				26. INFORMANT'S NAME (Type/Print) <b>MARY KATHLEEN WADE</b>			
27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>439 HARDING AVE. ODENTON, MD 21113</b>				28. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			
29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MEADOWRIDGE MEMORIAL PARK 8-3 ELKBRIDGE, MD</b>				30. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Hays Hopkins</b>			
31. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061</b>				32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary arrest</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. <b>Acute myocardial infarction</b> c. <b>Atherosclerotic cardiovascular disease</b> d.			
33. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Obesity, Diabetes mellitus</b>				34. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
35. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				36. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
37. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				38. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
39. DATE OF INJURY (Month, Day, Year) <b>28. DATE OF INJURY</b>				40. TIME OF INJURY <b>29. INJURY AT WORK?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
41. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>29. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>				42. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
43. SIGNATURE AND TITLE OF CERTIFIER <b>DR IRA KAPLAN</b>				44. LICENSE NUMBER <b>D25611</b>			
45. DATE SIGNED (Month, Day, Year) <b>8/29/91</b>				46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>DR IRA KAPLAN/7845 OAKWOOD ROAD/GLEN BURNIE, MD 21061</b>			
47. DATE FILED (Month, Day, Year) <b>AUG 30 1991</b>				48. REGISTRAR'S SIGNATURE <b>R. Davidson-Randall</b>			



91 23617

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANN HOPE ABELL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 7, 1991</b>		3. TIME OF DEATH <b>9:25 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>215-36-3889</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 31, 1929</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>St Mary's Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Leonardtwn</b>		9c. COUNTY OF DEATH <b>St. Mary;s</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S CO.</b>		10c. CITY, TOWN OR LOCATION <b>HOLLYWOOD</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RT. 1, BOX 1252</b>				10f. ZIP CODE <b>20636</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH GRADE</b> College (1-4 or 5 +)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>	
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE WILLARD CLARKE, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JULIA CHRISTINE NEWTON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOSEPH B. ABELL, SR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 1, BOX 1252, HOLLYWOOD, MARYLAND 20636</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. JOHN'S CATHOLIC</b>		20c. LOCATION — City or Town, State <b>8/10/91 HOLLYWOOD, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David A. Simmons</i>				22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Breast Cancer</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. [Signature]</i>				29c. LICENSE NUMBER <b>D25-220</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID ALLEN M.D. LEONARDTOWN</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 '91</b>				32. REGISTRAR'S SIGNATURE <i>Juha Davidson-Randell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11 83215

George Washington 1799

91 23618

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ZARIN AKRAM</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 7, 1991</b>		3. TIME OF DEATH <b>1:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-17-8191</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-31-12</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Grosvenor Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Gaithersburg</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8857 Cross Country Place</b>				10f. ZIP CODE <b>20879</b>		10g. CITIZEN OF WHAT COUNTRY? <b>Afghanistan</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>9 years</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Khodadad Youssofi</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gohar Youssofi</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Hedayatullah Akram</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as # 10</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>George Washington Cemetery</b>		20c. LOCATION — City or Town, State <b>Adelphi, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald V. Borgwardt</b>				22. NAME AND ADDRESS OF FACILITY <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cardiopulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Acute Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Cervical Tuberculosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CVA</b>						Approximate Interval Between Onset and Death <b>8/7/91</b> <b>8/91</b> <b>1990</b> <b>1990</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASLVD, HBP</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>DBP Strick</b>				29c. LICENSE NUMBER <b>D17729</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>G B Paton</b> <b>9221 Lakesville Rd SS, Md 20910</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 53219

91 23619

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RIVKA (AKA "RICCI") MARIE AUGUST</b>						2. DATE OF DEATH MONTH <b>8</b> DAY <b>9</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:55 P M</b>							
4. SOCIAL SECURITY NUMBER <b>109-16-8466</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-26-20</b>		8. BIRTHPLACE (State or Foreign Country) <b>USA</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSP</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
10e. STREET AND NUMBER <b>9225 Colesville Road</b>						10f. ZIP CODE <b>20910</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Sol Stein</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Cogan</b>									
19a. INFORMANT'S NAME (Type/Print) <b>George August (husband)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9225 Colesville Rd., Silver Spring, MD. 20910</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King David Memorial Garden 8/11</b>		20c. LOCATION — City or Town, State <b>Falls Church, VA.</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank A. Hume</i>						22. NAME AND ADDRESS OF FACILITY <b>Danzansky-Goldberg Memorial Chapels, Inc, 1170 Rockville Pike, Rockville, MD. 20852</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA OF THE BREAST</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <b>12 YRS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward A. Beeman MD</i>		29c. LICENSE NUMBER <b>D03604</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUG 9, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EDWARD A BEEMAN, M.D. 8830 CAMERON ST. SILVER SPRING MD 20910</b>															
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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91 23620

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ERIC R. ANDERSON				2. DATE OF DEATH MONTH DAY YEAR AUGUST 13 1991		3. TIME OF DEATH 8:30 A M	
4. SOCIAL SECURITY NUMBER 210-09-8746		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 16, 1991	
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE'S		10c. CITY, TOWN OR LOCATION LAUREL		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 14841 BELLE AMI DRIVE				10f. ZIP CODE 20707		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BRICK LAYER/STONE MASON		16b. KIND OF BUSINESS/INDUSTRY PENNSYLVANIA STATE			
17. FATHER'S NAME (First, Middle, Last) OSCAR ADOLPH ANDERSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) AMELIA ANTONSON			
19a. INFORMANT'S NAME (Type/Print) CAROL HOBSON (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14841 BELLE AMI DRIVE LAUREL, MARYLAND 20708					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) I.O.O.F. Cemetery		DATE		20c. LOCATION — City or Town, State Brisbin, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ray B...</i>		22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>cardiorespiratory failure</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>myocardial infarction</i> <i>hypertension</i> <i>arteriosclerosis</i> <i>hyperlipidemia</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>hypertension</i> <i>myocardial infarction</i> <i>arteriosclerosis</i> <i>hyperlipidemia</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DGA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Lewis H. Dennis</i>				29c. LICENSE NUMBER D01499		29d. DATE SIGNED (Month, Day, Year) 8/13/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LEWIS H. DENNIS, M.D. 6201 GREENBELT ROAD#U-17 COLLEGE PARK, MARYLAND 20740							
31. DATE FILED (Month, Day, Year) AUG 14 '91		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



FOX VINE

91 23621

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROSE ELIZABETH ADDISON</b>				2. DATE OF DEATH MONTH <b>Aug</b> DAY <b>1</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>7:58 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-56-0757</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 18 1900</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>7855 Burnside Rd.</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Landover</b>		8c. COUNTY OF DEATH <b>Prince George's</b>	
9. RESIDENCE OF DECEDENT				10a. STATE <b>Md.</b>		10b. COUNTY <b>P.G.</b>	
10c. CITY, TOWN OR LOCATION <b>Landover</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>7855 Burnside Rd.</b>				10f. ZIP CODE <b>20785</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
<b>Elementary/Secondary (0-12)</b> <b>6th</b>		<b>College (14 or 5+)</b>		<b>Domestic</b>		<b>Cleaning</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Samuel Addison</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carrie Harrison</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alberta T. Ford</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as # 10 above</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Olivet Cem. 8/6/91</b>		20c. LOCATION — City or Town, State <b>Wash., D.C.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gary W. Pratt</b>				22. NAME AND ADDRESS OF FACILITY <b>H.S. Washington &amp; Sons, INC. 4925 Burroughs Ave., N.E.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Cardiac arrest</b>							
b. <b>arteriosclerotic cardiovascular disease</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
c. <b></b>							
d. <b></b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE NOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>W. J. Waller</b>				29c. LICENSE NUMBER <b>D12879</b>		29d. DATE SIGNED (Month, Day, Year) <b>Aug 1, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ROBERTO VALE, M.D., 10701 TRAFALGAR DR., LARGO, MD 20772</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WALLACE G. ALLEN JR.				2. DATE OF DEATH MONTH 08 DAY 07 YEAR 1991		3. TIME OF DEATH 3:12 A.M.	
4. SOCIAL SECURITY NUMBER 214-04-5422		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 16 YRS.		7. DATE OF BIRTH (Month, Day, Year) September 6, 1974	
8. BIRTHPLACE (State or Foreign Country) Wash. D.C.				9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY	
9c. COUNTY OF DEATH PRINCE GEORGES							
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY PR. GEO.		10c. CITY, TOWN OR LOCATION Capitol Heights		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6938 Walker Mill Rd. #C-1				10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grad		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Wallace George Allen SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Donna Harrison			
19a. INFORMANT'S NAME (Type/Print) Donna Contee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6938 Walker Mill Rd. #C-1, Capitol Heights, MD. 20743			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Cemetery 8/10		DATE 8/10		20c. LOCATION — City or Town, State Landover, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John T. Stewart III 685				22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 4001 Benning Rd. N.E. Wash. D.C. 20019			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot wounds of Chest and wrist DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? X YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 08 07 1991		28b. TIME OF INJURY 2:17 A		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) ON STREET		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3129 75th. AVE. P.G. COUNTY			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John Davidson-Randall MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 08-07-1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. LARON LOCKE M.D. 111 PENN STREET BALTIMORE MARYLAND 21201							
31. DATE FILED (Month, Day, Year) AUG 13 '91		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) QUEEN RUBY AYRES				2. DATE OF DEATH MONTH DAY YEAR AUGUST 12, 1991		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 212-40-7856		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 6, 1942	
8. BIRTHPLACE (State or Foreign Country) SNOWHILL, MD.		9a. FACILITY NAME (If not institution, give street and number) 3901 MARKET STREET		9b. CITY, TOWN OR LOCATION OF DEATH SNOWHILL		9c. COUNTY OF DEATH WORCESTER	
RESIDENCE OF DECEDENT							
10a. STATE MD.		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION SNOWHILL		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 3901 MARKET STREET		10f. ZIP CODE 21863		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: X		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1YR.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AIDE		16b. KIND OF BUSINESS/INDUSTRY HEAD START PROGRAM			
17. FATHER'S NAME (First, Middle, Last) WARNER BECKETT				18. MOTHER'S NAME (First, Middle, Maiden Surname) HELEN BISHOP			
19a. INFORMANT'S NAME (Type/Print) CLIFTON AYRES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADDRESS SAME AS ABOVE			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) EBENEZER UM CH. CEMETERY		20c. LOCATION — City or Town, State MT. WESLEY, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Loretta B. Jolley</i>		22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL, RTE. 2. BOX 920 SALISBURY, MD. 21801					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 4/91
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gregory N. Thompson</i>		29c. LICENSE NUMBER D 3-734		29d. DATE SIGNED (Month, Day, Year) 8/16/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gregory N. Thompson, M.D., PGHMC, FL. C2, SALISBURY MD 21801							
31. DATE FILED (Month, Day, Year) AUG 16 '91		32. REGISTRAR'S SIGNATURE <i>John H. ...</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>William F. Adams</b>				2. DATE OF DEATH MONTH <b>August</b> DAY <b>16</b> , YEAR <b>1991</b>		3. TIME OF DEATH <b>3:00 p m</b>	
4. SOCIAL SECURITY NUMBER <b>215-26-4542</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02/01/22</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Deer's Head Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Talbot</b>		10c. CITY, TOWN OR LOCATION <b>Easton</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>311 Brooklyn Avenue</b>			
10f. ZIP CODE <b>21601</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4th</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chicken Catcher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Poultry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Adams</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Eary Lake Adams</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ms. Bessie Friend</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>311 Brooklyn Ave., Easton, MD 21601</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Washington Cemetery</b>		20c. LOCATION — City or Town, State <b>Hurlock, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael F. Eskow</b>				22. NAME AND ADDRESS OF FACILITY <b>Frampton-Hawkins-Eskow Funeral Home PO Bx 43, Federalsburg, MD 21632</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma colon</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>11 mos.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Virginia A. Dulany M.D.</b>				29c. LICENSE NUMBER <b>D33905</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/16/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Deer's Head Center Virginia A. Dulany P.O. Box 2018 Emerson Ave. Salisbury, Md. 21801</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 20 '91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death on the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM:18 per FH  
G-680 10/21/91 cm

91 23625

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary H. Bamberger</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:19 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-38-2066</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5/16/1899</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York, New York</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. CITY, TOWN OR LOCATION <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Chevy Chase</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4450 S. Park Avenue #1002</b>	
10f. ZIP CODE <b>20815</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>School teacher</b>				16b. KIND OF BUSINESS/INDUSTRY <b>elementary school</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Hotchkiss</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Harriet Madison HARRIET MATTESON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Fred H. Bamberger</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4450 S. Park Ave., #1002, Chevy Chase, Md. 20815</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parklawn Cemetery Aug. 16, 91</b>			
20c. LOCATION — City or Town, State <b>Rockville, Md.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Deirdre O'Hara</b>			
22. NAME AND ADDRESS OF FACILITY <b>DeVol Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>2222 Wisconsin Ave., N.W., Washington, D.C.</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b> Approximate Interval Between Onset and Death a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>Aug 16 91</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Alfred Baer, MD</b>				29c. LICENSE NUMBER <b>100197</b>			
29d. DATE SIGNED (Month, Day, Year) <b>August 13, 1991</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ALFRED BAER, M.D.</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 16 91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Rodell</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GREGORY LOYCE BELT				2. DATE OF DEATH MONTH DAY YEAR AUGUST 13, 1991		3. TIME OF DEATH 9:10 AM	
4. SOCIAL SECURITY NUMBER 403-94-3780		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 27 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 26, 1963	
9a. FACILITY NAME (If not institution, give street and number) AT HOME				9b. CITY, TOWN OR LOCATION OF DEATH COLTON'S POINT		9c. COUNTY OF DEATH ST. MARY'S	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ST. MARY'S		10c. CITY, TOWN OR LOCATION COLTON'S POINT		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. BOX 73				10f. ZIP CODE 20626		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH GRADE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DRAG LINE OPERATOR		16b. KIND OF BUSINESS/INDUSTRY GRAVEL COMPANY	
17. FATHER'S NAME (First, Middle, Last) DENNIS PAUL BELT				18. MOTHER'S NAME (First, Middle, Maiden Surname) JANIS FAYE JONES			
19a. INFORMANT'S NAME (Type/Print) VERONICA ANN BELT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 73, COLTON'S POINT, MARYLAND 20626			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name) CHARLES MEMORIAL GARDENS		DATE		20c. LOCATION — City or Town, State LEONARDTOWN, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MARYLAND 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Leukemia</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <i>1 yr</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David C. Allen</i>				29c. LICENSE NUMBER D25230		29d. DATE SIGNED (Month, Day, Year) 8/13/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID C. ALLEN, M.D. LEONARDTOWN, MARYLAND 20650							
31. DATE FILED (Month, Day, Year) AUG 14 '91				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


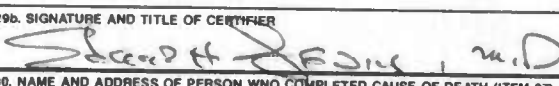

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>LAWRENCE EUGENE BARRY, SR.</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:18 A M</b>	
4. SOCIAL SECURITY NUMBER <b>578-42-0054</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-5-32</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MISSOURI</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9b. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>ROCKVILLE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2 IRIS CT</b>		10f. ZIP CODE <b>20853</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>	
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ELECTRICIAN</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>LAWRENCE A. BARRY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CATHERINE GRACE BAKER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>HELEN JEAN BARRY (WIFE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2 IRIS COURT ROCKVILLE, MARYLAND 20853</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GATE OF HEAVEN CEMETERY 8/16</b>		20c. LOCATION — City or Town, State <b>SILVER SPRING, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Pulmonary Arrest</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Due to (or as a consequence of):</b> <b>Accompanied by stroke</b> b. <b>Due to (or as a consequence of):</b> c. <b>Due to (or as a consequence of):</b> d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pulmonary Embolism</b> <b>Drug Induced Hypertension</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Edgar H. Levin, M.D.</b>				29c. LICENSE NUMBER <b>D10620</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/13/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EDGAR H. LEVIN, M.D. 9801 GEORGIA AVENUE #341 SILVER SPRING, MARYLAND 20910</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 '91</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Harold Birnbaum</i>				2. DATE OF DEATH MONTH <i>8</i> - DAY <i>13</i> - YEAR <i>91</i>		3. TIME OF DEATH <i>7:15A</i>	
4. SOCIAL SECURITY NUMBER <i>545-64-9243</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>74</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>Nov. 18, 1916</i>		8. BIRTHPLACE (State or Foreign Country) <i>New York</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Suburban Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Bethesda</i>		9c. COUNTY OF DEATH <i>Montgomery</i>	
10a. STATE <i>Md.</i>				10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Wheaton</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>13801 Bonsal La.</i>			
10f. ZIP CODE <i>20906</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>W.W. 11</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>5+</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Physician</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Medical</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Max Birnbaum</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bertha Kreindler</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Olive B. Birnbaum</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>13801 Bonsal Ln. Wheaton, Md. 20906</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Chambers Crematory</i>		20c. LOCATION — City or Town, State <i>8/14/91 Riverdale, Md.</i>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE # <i>670</i> <i>Thomas S. Chambers</i>				22. NAME AND ADDRESS OF FACILITY <i>W.W. Chambers Co. Inc. 9241 Columbia Blvd. Sil. Spg. Md. 20910</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic adenocarcinoma of liver</i>							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): <i>Probable Cholangiocarcinoma</i>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic obstructive pulmonary disease, Coronary heart disease, Asymptomatic septal hypoplasia</i>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sidney S. Chen, MD</i>				29c. LICENSE NUMBER <i>D01193</i>		29d. DATE SIGNED (Month, Day, Year) <i>8-13-91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Sidney S. Chen, MD, 121 Congress Hill Lane, Rockville, MD 20852</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 14 '91</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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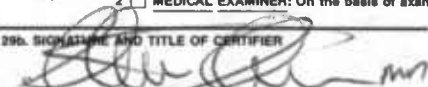

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91 23629

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLYDE MILTON BRYAN, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG 14, 1991</b>		3. TIME OF DEATH P M <b>9:30 P</b>	
4. SOCIAL SECURITY NUMBER <b>239-40-6805</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB 26 1931</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NORTH CAROLINA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>	
10c. CITY, TOWN OR LOCATION <b>GAITHERSBURG</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>813 DIAMOND AVENUE</b>	
10f. ZIP CODE <b>20878</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1949 - 1979</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>U.S. ARMY</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DEFENSE</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>CLYDE MILTON BRYAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FLORENCE LILLIAN LUCAS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BETTY L. BRYAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>813 DIAMOND AVENUE, GAITHERSBURG, MD 20878</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>August 19, 1991</b> <b>MONTLAWN MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>RALEIGH NORTH CAROLINA</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0335</b>	
22. NAME AND ADDRESS OF FACILITY <b>ROBERT A. PUMPHREY FUNERAL HOME/ BETHESDA-CHEVY CHASE, INC. 7557 WISCONSIN AVENUE BETHESDA, MARYLAND 20814</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. AGGRESSIVE METASTATIC RHABDOID SARCOMA</b> <b>Due TO (OR AS A CONSEQUENCE OF):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. <b>Due TO (OR AS A CONSEQUENCE OF):</b> c. <b>Due TO (OR AS A CONSEQUENCE OF):</b> d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>53753 (NJ)</b>		29d. DATE SIGNED (Month, Day, Year) <b>15 AUG 91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S. J. SHERIS, LT, MC, USNR</b>				<b>NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20889-5000</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 19 '91</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23630

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Virginia H. Bauer</i>				2. DATE OF DEATH MONTH <i>August</i> DAY <i>18</i> YEAR <i>1991</i>				3. TIME OF DEATH <i>6:40 P M</i>	
4. SOCIAL SECURITY NUMBER <i>160-24-5820</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>79</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	7. DATE OF BIRTH (Month, Day, Year) <i>July 9, 1912</i>		8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Manor Care Nursing</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>			9c. COUNTY OF DEATH <i>Montgomery</i>		
RESIDENCE OF DECEDENT									
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <i>2501 Musgrove Road</i>				10f. ZIP CODE <i>20904</i>		10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>College</i>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Switchboard Operator</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Own Home / Hospital</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Edward Dunn Hamilton</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ella Caroline Allen</i>					
19a. INFORMANT'S NAME (Type/Print) <i>Carol B. Clarke</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1112 Brantford Avenue, Silver Spring, MD 20904</i>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Suburban Crematory</i>			20c. LOCATION — City or Town, State <i>Silver Spring, Maryland</i>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eileen H. Rapp</i>				22. NAME AND ADDRESS OF FACILITY <i>Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Cardiomyopathy</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Coronary Artery Disease</i>								Approximate Interval Between Onset and Death <i>&gt; 2-3y</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Insulin Dependent Diabetes mellitus</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rahul G. Gupta MD</i>				29c. LICENSE NUMBER <i>D32417</i>		29d. DATE SIGNED (Month, Day, Year) <i>08/18/91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Rahul G. Gupta MD 15620 Georgia Ave #218 Silver Spring MD 20902</i>									
31. DATE FILED (Month, Day, Year) <i>AUG 19 '91</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23631

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THEODORE JEROME BARNES				2. DATE OF DEATH MONTH DAY YEAR AUGUST 24, 1991		3. TIME OF DEATH 0525 M	
4. SOCIAL SECURITY NUMBER 216-14-6073		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) JAN. 9, 1917	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) NAVAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH PATUXENT RIVER	
9c. COUNTY OF DEATH ST. MARY'S				10a. STATE MARYLAND		10b. COUNTY ST. MARY'S	
10c. CITY, TOWN OR LOCATION RIDGE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER STAR ROUTE, BOX 57	
10f. ZIP CODE 20680				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PAINTER		16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION	
17. FATHER'S NAME (First, Middle, Last) JOHN E. BARNES				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE ELIZABETH TAYLOR			
19a. INFORMANT'S NAME (Type/Print) MRS. EDNA R. BARNES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) STAR ROUTE, BOX 57, RIDGE, MARYLAND 20680			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, institution or other place) ST. PETER CLAVER CATHOLIC		20c. DATE 8/28	
20d. LOCATION — City or Town, State ST. INIGOE, MD.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Barnes</i>			
22. NAME AND ADDRESS OF FACILITY BRINSFIELD FUNERAL HOME, P.A. P.O. BOX 279, LEONARDTOWN, MARYLAND 20650				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Uncontrolled Contraception</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David M. Federle</i>				29c. LICENSE NUMBER D34198		29d. DATE SIGNED (Month, Day, Year) 8/28/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID M. FEDERLE, M.D., 600 MOAKLEY STREET, SUITE #205, LEONARDTOWN, MD. 20650							
31. DATE FILED (Month, Day, Year) AUG 29 '91				32. REGISTRAR'S SIGNATURE <i>Lisa Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23632

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY ELIZABETH BROWN</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6 15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>121-03-4619</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04-18-1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Greater Laurel-Beltsville Hospital</b>			
9b. CITY, TOWN OR LOCATION OF DEATH <b>Laurel</b>				9c. COUNTY OF DEATH <b>Prince George's</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Laurel</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>14200 Laurel Park Drive #76</b>				10f. ZIP CODE <b>20707</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>NO</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>NO</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (9-12)</b> <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>payroll supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Gov't.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edward Lawrence Brown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Rose Adams</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edward L. Brown</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Mayflower Drive, Port Jefferson, New York 11777</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Charles Cemetery</b>		20c. LOCATION — City or Town, State <b>Farmingdale, New York</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A.</b> <b>4739 BALT. AVE., HYATTSVILLE, MD. 20781</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial infarction</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>D24942</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-14-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Gregory A. Compton MD 8317 Avery Lane Laurel MD 20707</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 '91</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SEP 11

91 23633

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SARALUE S BENNETT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 8, 1991</b>		3. TIME OF DEATH P M <b>2:26 P</b>	
4. SOCIAL SECURITY NUMBER <b>234-60-8241</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>51</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 9, 1939</b>	
8. BIRTHPLACE (State or Foreign Country) <b>W. Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Suitland</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3392 Curtis Drive, Apt. T-2</b>	
10f. ZIP CODE <b>20746</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Science Teacher</b>				16b. KIND OF BUSINESS/INDUSTRY <b>D. C. School System</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Milo Edison Sovine</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sybill Irene Hash</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David L. Sovine</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9529 Fort Foote Rd. Ft. Washington, Md. 20744</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation / 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Barlow Bonsall Crematory 8/13/91</b>			
20c. LOCATION — City or Town, State <b>Charleston, W. Va.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>			
22. NAME AND ADDRESS OF FACILITY <b>George P. Kalas Funeral Home</b> <b>6160 Oxon Hill Rd. Oxon Hill, Md. 20745</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>multiorgan failure</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>sepsis</b> b. <b>ARDS - Adult Respiratory Distress Syndrome</b> c. <b>Liver transplant</b> d. <b>19d</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>V.S. Abraham, Johns Hopkins Hosp 600 N. Wolfe St</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1-500-12-00

C Items; 23 part I & 27 per me  
FOR STATE G-679 9/6/91 REGISTRAR reb  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES DOUGLAS BEST</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 08 91</b>		3. TIME OF DEATH <b>9:30 A M</b>					
4. SOCIAL SECURITY NUMBER <b>246 78 3201</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>42 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 31, 1948</b>		8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>6902 SEAT PLEASANT DRIVE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SEAT PLEASANT</b>			9c. COUNTY OF DEATH <b>PRINCE GEORGE</b>				
10a. STATE <b>Maryland</b>			10b. COUNTY <b>Prince George's</b>			10c. CITY, TOWN OR LOCATION <b>Seat Pleasant</b>			10d. INSIDE CITY LIMITS? <b>1 X YES 2 NO</b>		
10e. STREET AND NUMBER <b>6902 Seat Pleasant</b>				10f. ZIP CODE <b>20743</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <b>1 X Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8th</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>			16b. KIND OF BUSINESS/INDUSTRY <b>PVT</b>				
17. FATHER'S NAME (First, Middle, Last) <b>A.D. Best</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Summerville</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Rudolph Best</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9302 Vaughn Place Seabrook, MD 20706</b>							
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hamilton Gardens</b>		DATE <b>8-13-91</b>		20c. LOCATION — City or Town, State <b>North Carolina</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Diabetes Mellitus</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> d.										Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <b>1 X YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>			26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DDA OTHER: 4 Nursing Home 5 X Residence 6 Other (Specify)</b>								
27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald G. Wright MD</b>					29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/09/91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dermog Gurigan MD Deme 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>			32. REGISTRAR'S SIGNATURE 								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information on the death certificate is to be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows an injury, or other traumatic event, the medical examiner must be notified at once.



91 23635

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frances Estelle Becraft				2. DATE OF DEATH MONTH DAY YEAR August 17, 1991		3. TIME OF DEATH 9:30 A.M.	
4. SOCIAL SECURITY NUMBER 579-26-3047		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) March 6, 1920	
8. BIRTHPLACE (State or Foreign Country) Virginia				9a. FACILITY NAME (If not institution, give street and number) 5303 Lackawanna St.		9b. CITY, TOWN OR LOCATION OF DEATH college Park	
9c. COUNTY OF DEATH Prince Georges				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION College Park				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5303 Lackawanna St.	
10f. ZIP CODE 20746				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) John B. Green				18. MOTHER'S NAME (First, Middle, Maiden Surname) Betty Thompkins Morgan			
19a. INFORMANT'S NAME (Type/Print) Steven L. Becraft				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4604 Tonquil St. Beltsville, MD. 20705			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 8/18/91		20c. LOCATION — City or Town, State Alexandria, VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Boya E. Neuback</i>				22. NAME AND ADDRESS OF FACILITY 4308 Suitland Rd. Robert E. Wilhelm, Inc. Suitland, MD. 20746			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pancreatic cancer - inoperable</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>MKT [Signature] Attending</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 8/17/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Madhu K. Mohan, M.D. 6504 Kenilworth Ave. Phvendale Md 20737							
31. DATE FILED (Month, Day, Year) AUG 19 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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12/1/82



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>STANLEY BRITT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 09 1991</b>		3. TIME OF DEATH <b>0753 A M</b>	
4. SOCIAL SECURITY NUMBER <b>577-66-7648</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>43</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-08-48</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>in woods at dead end of Danes and Sheriff Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Fairmount</b>		9c. COUNTY OF DEATH <b>Prince Georges</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Prince Georges</b>		10c. CITY, TOWN OR LOCATION <b>Seat Pleasant</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6402 Seat Pleasant Drive</b>				10f. ZIP CODE <b>20743</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>7-69 to 4-71</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Custodian</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private-Service</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Roosevelt Britt, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillie Morrissey</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bernice Britt</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6402 Seat Pleasant Dr., Seat Pleasant MD 20743</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Forest Hill Mem. Cem. 8-17-91 Clinton, MD</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John P. Strickland</i>				22. NAME AND ADDRESS OF FACILITY <b>Strickland Services 9507 Silver Fox Turn Clinton, MD 20735</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE COCAINE INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>in woods</b>					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY <b>08-09-1991</b>		28b. TIME OF INJURY <b>7:45A</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Unknown WOODED AREA</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Unknown DANCES SHERIFF'S ROAD P.G. CO., MD</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 09 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald G. Wright MD DCME 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 19 '91</b>		32. REGISTRAR'S SIGNATURE <i>John P. Strickland</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23637

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Carolyn V. Butler</u>				2. DATE OF DEATH MONTH <u>08</u> DAY <u>19</u> YEAR <u>91</u>		3. TIME OF DEATH <u>9:15</u> M	
4. SOCIAL SECURITY NUMBER <u>218-62-9096</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>34</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>8-11-57</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>Holly Cross Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Silver Spring</u>		9c. COUNTY OF DEATH <u>Montgomery</u>	
10a. STATE <u>PA</u>		10b. COUNTY <u>Franklin</u>		10c. CITY, TOWN OR LOCATION <u>Greencastle</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>2496 Williamson Rd.</u>				10f. ZIP CODE <u>17225</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>2</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Real estate agent</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Real estate</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Marvin E. Stewart</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Catherine Kelly</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Catherine Kernes</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2496 Williamson Rd. Greencastle, PA 17225</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Smithsburg Crematory</u>		20c. LOCATION — City or Town, State <u>Smithsburg, MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Robert C. May</u> Robert C. May				22. NAME AND ADDRESS OF FACILITY <u>112 E. Baltimore St. Minnich-Miller-May Funeral Home Greencastle, PA 17225</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>① Anasarca</u> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <u>② Mediastinal Fibrosis secondary to Radiation</u> <u>③ Chronic Respiratory Failure</u>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Previous Hodgkins Lymphoma</u> <u>Severe Malnutrition</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Stephen Calhoun MD</u>				29c. LICENSE NUMBER <u>D28181</u>		29d. DATE SIGNED (Month, Day, Year) <u>8/20/91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type/Print) <u>1011 North Capitol St., NE, Washington, DC 20002</u>							
31. DATE FILED (Month, Day, Year) <u>AUG 23 '91</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rendell</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1970

91 23638

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Catherine Amanda BLACKBURN</i>				2. DATE OF DEATH MONTH <i>Aug</i> DAY <i>22</i> YEAR <i>91</i>		3. TIME OF DEATH HOUR <i>10</i> MIN <i>A</i>	
4. SOCIAL SECURITY NUMBER <i>212-24-3436</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>83</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Feb. 2, 1908</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington County Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Hagerstown</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1036 Brinker Dr., Apt. 102</i>				10f. ZIP CODE <i>21740</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>white</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i> <i>10</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>sales clerk</i>		16b. KIND OF BUSINESS/INDUSTRY <i>department store</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Victor M. Cromer</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Nettie C. Rhodes</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Frederick R. Blackburn</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1265 Cedar Park Place, Stone Mountain, Ga. 30083</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Rest Haven Cemetery</i>		DATE <i>8/26</i>		20c. LOCATION — City or Town, State <i>Hagerstown, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott M. Minnich</i>				22. NAME AND ADDRESS OF FACILITY <i>MINNICH FUNERAL HOME</i> <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Multiple injury, Head &amp; extremities</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>b. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>c. DUE TO (OR AS A CONSEQUENCE OF):</i> <i>d.</i>							Approximate Interval Between Onset and Death <i>5 days</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <i>Street</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Street</i>		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>8/22/91</i>		28b. TIME OF INJURY <i>10 PM</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>Struck by car</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Street</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>415 E. Wilson Blvd Hagerstown Md</i>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. N. Weeks M.D.</i>				29c. LICENSE NUMBER <i>D11266</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/26/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>H. N. Weeks M.D. 550 Northern Ave Hager MD 21740</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 28 91</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1957-01-12



91 23639

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY E BRITTINGHAM</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0500</b> M	
4. SOCIAL SECURITY NUMBER <b>216-38-8794</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) <b>47</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>MAY 4, 1944</b>		8. BIRTHPLACE (State or Foreign Country) <b>BERLIN, MD.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>WORCESTER</b>		10c. CITY, TOWN OR LOCATION <b>BERLIN</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>101 JEFFERSON STREET</b>				10f. ZIP CODE <b>21811</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CHEF</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MILTON LOCKWOOD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BEULAH BRITTINGHAM</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARY BRITTINGHAM</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>TRAPPE CK, APT. 14, BERLIN, MD. 21811</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, date, and time) <b>BERLIN, EVERGREEN</b>		DATE <b>8-17</b>		20c. LOCATION — City or Town, State <b>BERLIN, MD. 21811</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Louella B. Jolley</i>				22. NAME AND ADDRESS OF FACILITY <b>JOLLEY MEMORIAL CHAPEL, RTE. 2, BOX 920 SALISBURY, MD. 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebellar hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>3-4 hrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Seasonal allergies</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edwin H. Bell</i>				29c. LICENSE NUMBER <b>D28587</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-12-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Edwin H. Bell 508 S. DIVISION ST SALISBURY MD 21807</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 91</b>		32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the funeral director.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO



FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Brian Christopher Ball</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>5:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>452-67-5253</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>15</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-27-76</b>	
8. BIRTHPLACE (State or Foreign Country) <b>TEXAS</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Peninsula General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>TEXAS</b>		10b. COUNTY <b>GRAYSON</b>		10c. CITY, TOWN OR LOCATION <b>TRENTON</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RT. 1 BOX 30</b>				10f. ZIP CODE <b>75490</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>9 YEARS</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HIGH SCHOOL STUDENT</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>BRIAN LEE BALL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JANICE HOLLAND BALL</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BRIAN LEE BALL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 1 BOX 30 TRENTON, TX 75490</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>8-18-91</b> <b>4</b> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BLUE RIDGE CEMETERY</b>		20c. LOCATION — City or Town, State <b>BLUE RIDGE, TEXAS</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald G. Wright</i>				22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME</b> <b>501 SNOW HILL RD SALISBURY, MD 21801</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACUTE ETHANOL INTOXICATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>2</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <b>3</b> <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <b>4</b> <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>							
29c. LICENSE NUMBER <b>O.C.M.E.</b>				29d. DATE SIGNED (Month, Day, Year) <b>August 12, 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald G. Wright M.D. 111 Penn St. Baltimore, Md. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>		32. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Pondell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01505 10

01505 10

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RICHARD EDWIN BOOTH</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>213-22-9843</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-9-30</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>612 N. PINEHURST AVENUE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>612 N. PINEHURST AVENUE</b>			
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>KOREAN WAR</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b> College (1-4 or 5+) <b>1 YEAR</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SELF EMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CONTRACTOR</b>	
17. FATHER'S NAME (First, Middle, Last) <b>EDWIN WILSON BOOTH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA BELL TILGHMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARJORIE T. BOOTH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>612 N. PINEHURST AVE. SALISBURY, MD 21801</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARSONS CEMETERY</b>		20c. LOCATION — City or Town, State <b>SALISBURY, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John R. Bellway</i>				22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME 501 SNOW HILL RD. SALISBURY, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic Adenocarcinoma of lung</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John R. Bellway</i> M.D.				29c. LICENSE NUMBER <b>D 20507</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/14/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph A. Grasso 145 E. Carroll St. Salisbury MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>				32. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Allen Alonzo Black</b>		2. DATE OF DEATH MONTH DAY YEAR <b>August 24, 1991</b>		3. TIME OF DEATH <b>0815 am</b>	
4. SOCIAL SECURITY NUMBER <b>218 16 5211</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>4-3-1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Calvert Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Prince Frederick</b>		9c. COUNTY OF DEATH <b>Calvert</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Calvert</b>		10c. CITY, TOWN OR LOCATION <b>Owings</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7058 Old Solomons Island Road</b>		10f. ZIP CODE <b>20736</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Dock Master</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Boating/Marine</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Roland Black</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cleopatra Marshall</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Betty P. Black</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as 10 above</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Spring Hill Cem. 8-26-91</b>		20c. LOCATION — City or Town, State <b>Easton (Talbot) MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home, Owings, MD 20736</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>chronic congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>diabetes</b> <b>amputation</b> <b>R. atrial myxoma</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>D12705</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/24/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Emad Albanna Prince Frederick, Maryland 20678</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 26 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-00-00



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Charlotte Regina Bell				2. DATE OF DEATH MONTH DAY YEAR Aug. 24 1991		3. TIME OF DEATH 12:45 P M	
4. SOCIAL SECURITY NUMBER 218 50 5282		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 6/17/04	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Pleasant Living Conv.Center		9b. CITY, TOWN OR LOCATION OF DEATH Edgewater	
9c. COUNTY OF DEATH Anne Arundel				10a. STATE Maryland		10b. COUNTY Calvert	
10c. CITY, TOWN OR LOCATION Lusby				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 431 Stallion Lane	
10f. ZIP CODE 20657				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) Housewife				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Edward Burns				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Murphy			
19a. INFORMANT'S NAME (Type/Print) C. Patricia Schertle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as 10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cemetery		20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Rausch				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home MD 4405 Broomes Island Rd., Port Republic			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Colon Cancer DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER C. R. Jones M.D.				29c. LICENSE NUMBER D18524		29d. DATE SIGNED (Month, Day, Year) 26 Aug 91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)							
31. DATE FILED (Month, Day, Year) AUG 26 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the medical or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be placed in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8/28/2 10

10/2/2 10



91 23644

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY AGNES CURTIS</b>				2. DATE OF DEATH MONTH <b>August</b> DAY <b>9</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>09:20 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-32-6058</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APR. 27, 1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Mary's Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Leonardtwn</b>				9c. COUNTY OF DEATH <b>St. Mary's</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S</b>		10c. CITY, TOWN OR LOCATION <b>LEONARDTOWN,</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>GENERAL DELIVERY</b>				10f. ZIP CODE <b>20650</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7TH GRADE</b> College (1-4 or 5+) <b>COLLEGE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COOK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOSPITAL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE HENRY SWALES</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA YOUNG</b>					
19a. INFORMANT'S NAME (Type/Print) <b>MARY AGNES CURTIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>GENERAL DELIVERY, LEONARDTOWN, MARYLAND 20650</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHARLES MEMORIAL GARDENS 8/12/91</b>		20c. LOCATION — City or Town, State <b>LEONARDTOWN, MARYLAND</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael K. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MARYLAND 20650</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute Cerebrovascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):							
		c. DUE TO (OR AS A CONSEQUENCE OF):							
		d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Renal Failure, Diabetes Mellitus, Hypertension</i>									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James E. Boyd, M.D.</i>				29c. LICENSE NUMBER <b>D19917</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>James E. Boyd, M.D. Leonardtown, Maryland 20650</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 12 91</b>		32. REGISTRAR'S SIGNATURE <i>Richard Davidson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23645

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) Julia Ann Mc Carthy				2. DATE OF DEATH MONTH DAY YEAR Aug. 13, 1991		3. TIME OF DEATH 4:50 p. M	
4. SOCIAL SECURITY NUMBER 577-10-0281		8. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 28, 1900	
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 14 Blueberry Ridge Court			
10f. ZIP CODE 20854				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retail Clerk		16b. KIND OF BUSINESS/INDUSTRY Sales			
17. FATHER'S NAME (First, Middle, Last) Charles T. Anderson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nettie Moore			
19a. INFORMANT'S NAME (Type/Print) Robert J. Mc Carthy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery 8/16/91		20c. LOCATION — City or Town, State Brentwood, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00896	
22. NAME AND ADDRESS OF FACILITY De Vol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac arrest</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>End stage dementia</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Tube feeding</u> DUE TO (OR AS A CONSEQUENCE OF): <u>acute renal failure</u>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D31391		29d. DATE SIGNED (Month, Day, Year) Aug. 14, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suhair H. Abulfarag 19261 Montgomery Village Ave. #G-10 Gaithersburg, MD 20879							
31. DATE FILED (Month, Day, Year) AUG 16 '91		32. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



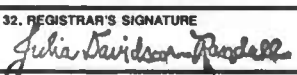
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23646

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JESSIE COLLEEN COX</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 18, 1991</b>		3. TIME OF DEATH <b>10:50 A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>355-07-5529</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUGUST 25, 1915</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1001 SPRING STREET #1115</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1001 SPRING STREET #1115</b>			
10f. ZIP CODE <b>20910</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SECRETARY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SOCIAL SECURITY ADMIN.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM ORVILLE COX</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FLORENCE CLARA REDMOND</b>			
19a. INFORMANT'S NAME (Type/Print) <b>IRENE KERR (SISTER)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3580 CONRAD AVENUE SAN DIEGO, CALIFORNIA 92117</b>					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MCINTURFF CEMETERY 8/22</b>		20c. LOCATION — City or Town, State <b>HAGARSTOWN, ILLINOIS</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>valvular Heart Disease, Mitral Regurgitation</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Recurrent Pulmonary Edema / Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>3 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Tracheobronchitis</b> <b>Diabetes mellitus</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER <b>D35162</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/19/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL SCHINDLER MD 106 Spring street Silver Spring, MD 20910</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 20 '91</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. TO THE REGISTRAR: This certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HOWE HIAER

MOTIONS 202

91 23647

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Burrell, Catherine</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8-10-91</b>		3. TIME OF DEATH <b>7:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>237 52 5951</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 27, 1925</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Southern Md Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton, Md.</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Landover</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3414 Dodge Park Rd.</b>	
10f. ZIP CODE <b>20785</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housekeeper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PVT</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Dave Ward</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alberta Applewhite</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Annie Morgan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6355 64th Ave. Riverdale, MD 20745</b>			
20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		20c. LOCATION — City or Town, State <b>8-17 Landover, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jimmy B. Neal</b>				22. NAME AND ADDRESS OF FACILITY <b>J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785</b>			
23. PART I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of ascending colon</b> Due to (or as a consequence of): <b>metastasis to the liver.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Hepatic failure.</b> <b>Condit. - respiratory and</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>CIRO D. MONTANEZ, MD</b>				29c. LICENSE NUMBER <b>D14156</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-10-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CIRO D. MONTANEZ, MD : 3308 Dodge PK Rd Landover MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





ITEMS:28a thru 28f per ME  
G-680 10/22/91 cm

91-4494-033

91 23648

FEH

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES SHERMAN COLES</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>4</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>09:50 A.M.</b>			
4. SOCIAL SECURITY NUMBER <b>579-74-1263</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>36</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-18-1955</b>		8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>529 67TH PLACE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CAPITOL HEIGHTS</b>			9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>		
10a. STATE <b>Md.</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Seat Pleasant</b>			10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>529 67th Pl.</b>				10f. ZIP CODE <b>20743</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Security Guard</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Government</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Alex Hodges</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosa Coles</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Rosa L. Sibert</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as #10 above</b>					
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Mem.Park 8/8/91</b>		DATE <b>8/8/91</b>		20c. LOCATION — City or Town, State <b>Landover, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Pratt</i>				22. NAME AND ADDRESS OF FACILITY <b>H.S. Washington &amp; Sons, Inc. 4925 Burroughs Ave., N.E.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. HEAD INJURIES</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>								Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input checked="" type="checkbox"/> Homicide <b>8</b> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY <b>8/4/91</b>		28b. TIME OF INJURY <b>UNKNOWN</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>UNKNOWN</b>	
29a. CERTIFIER (Check only one) <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>		29c. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>529 67th PLACE</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-5-1991</b>			
29e. SIGNATURE AND TITLE OF CERTIFIER <i>Frank J. Peretti, MD</i>				29f. LICENSE NUMBER <b>O.C.M.E.</b>		29g. DATE SIGNED (Month, Day, Year) <b>8-5-1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANK J. PERETTI, MD 111 PENN STREET BALTIMORE, MARYLAND 21201</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson Hendell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN—MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

DHMH-18 Rev 1/89



91 23650

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Andrew J. Coston				2. DATE OF DEATH MONTH DAY YEAR August 26, 1991		3. TIME OF DEATH 1:30 PM	
4. SOCIAL SECURITY NUMBER 216547791		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8/30/50	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Snow Hill		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 415 Covington Street				10f. ZIP CODE 21863		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Viet Nam		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) A.C. Helper		16b. KIND OF BUSINESS/INDUSTRY NASA			
17. FATHER'S NAME (First, Middle, Last) Sherman T. Coston Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Hilda Johnson			
19a. INFORMANT'S NAME (Type/Print) Dora Leonard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9621 Sea Hawk Rd., Berlin, Maryland 21811			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Zion Baptist Cemetery 21		DATE 21		20c. LOCATION — City or Town, State Snow Hill, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Dennis Funeral Home 110 Franklin St., Snow Hill, Md. 21863			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Artery Disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Coronary Artery Disease</i> <i>Coronary Artery Disease</i> <i>Coronary Artery Disease</i> <i>Coronary Artery Disease</i>							Approximate Interval Between Onset and Death <i>Min</i> <i>Yes</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Sarcoidosis</i> <i>Emphysema</i> <i>Coronary Artery Disease</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Seese MD</i>				29c. LICENSE NUMBER D02020		29d. DATE SIGNED (Month, Day, Year) 8/16/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Gary J. Green, 1000 Locust St. Sal. MD. 21801							
31. DATE FILED (Month, Day, Year) AUG 20 91		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR



REG. NO.

DHMH-16 Rev 1/89





DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

REG. NO.

DHMH-18 Rev 1/89



REG. NO.

DMMH-1A Rev 1/89

**THE HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

**THE FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

William W. Miller

91 23654

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

2



91 2365 5

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Velora E. Durst</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10 25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-32-3205</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>71</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>July 15, 1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Montgomery General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>14124 Grand Pre Rd.</b>				10f. ZIP CODE <b>20906</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Thomas T. Bittinger</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Della E. Wilt</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dona Flannigan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3315 Weeping Willow Ct. # 23 Silver Spring, Md. 20906</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Chambers Crematory 8/14/91</b>		20c. LOCATION — City or Town, State <b>Riverdale, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas S. Chamber</b> # 670				22. NAME AND ADDRESS OF FACILITY <b>W.W. Chambers Co. Inc.</b> <b>9241 Columbia Blvd. Silver Spring, Md. 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Myocardial Infarction</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute myocardial infarction</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>John Tauber</b>		29c. LICENSE NUMBER <b>208544</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-13-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Tauber 8218 Wisconsin Ave Bethesda</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 1

1. The first part of the report is a summary of the work done during the year.

2. The second part is a detailed account of the work done during the year.

3. The third part is a summary of the work done during the year.

4. The fourth part is a summary of the work done during the year.

5. The fifth part is a summary of the work done during the year.

6. The sixth part is a summary of the work done during the year.

7. The seventh part is a summary of the work done during the year.

8. The eighth part is a summary of the work done during the year.

9. The ninth part is a summary of the work done during the year.

10. The tenth part is a summary of the work done during the year.

11. The eleventh part is a summary of the work done during the year.

12. The twelfth part is a summary of the work done during the year.

13. The thirteenth part is a summary of the work done during the year.

14. The fourteenth part is a summary of the work done during the year.

15. The fifteenth part is a summary of the work done during the year.

16. The sixteenth part is a summary of the work done during the year.

17. The seventeenth part is a summary of the work done during the year.

18. The eighteenth part is a summary of the work done during the year.

19. The nineteenth part is a summary of the work done during the year.

20. The twentieth part is a summary of the work done during the year.

21. The twenty-first part is a summary of the work done during the year.

22. The twenty-second part is a summary of the work done during the year.

23. The twenty-third part is a summary of the work done during the year.

24. The twenty-fourth part is a summary of the work done during the year.

25. The twenty-fifth part is a summary of the work done during the year.

26. The twenty-sixth part is a summary of the work done during the year.

27. The twenty-seventh part is a summary of the work done during the year.



91 23656

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FREDERICK LEE DAVIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG. 7, 1991</b>		3. TIME OF DEATH <b>12:25 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>579-05-1972</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 25, 1903</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ST. MARY'S NURSING CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LEONARDTOWN</b>		9c. COUNTY OF DEATH <b>ST. MARY'S COUNTY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S COUNTY</b>		10c. CITY, TOWN OR LOCATION <b>HOLLYWOOD</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RT. 1, BOX 885</b>				10f. ZIP CODE <b>20636</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>3RD. GRADE</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TRUCK DRIVER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>LAUNDRY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GERTRUDE DAVIS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FRANK R. HOUSER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 1, BOX 885, HOLLYWOOD, MARYLAND 20636</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>NAZARENE CHURCH CEMETERY 8/10/91</b>		20c. LOCATION — City or Town, State <b>HOLLYWOOD, MARYLAND</b>		22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Frank R. Houser</i>				22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i></b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval between Onset and Death <i>Days</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Alzheimer's Disease</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David Allen, M.D.</i>				29c. LICENSE NUMBER <i>025230</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/9/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID ALLEN, M.D. LEONARDTOWN, MARYLAND 20650</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

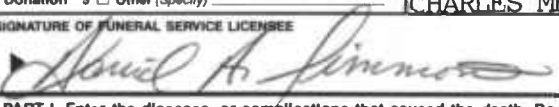

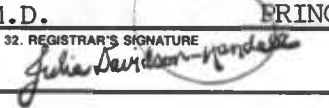
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91 23657

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELMER FRANCIS DENT, SR.</b>		2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 4 1991</b>		3. TIME OF DEATH <b>1515</b>	
4. SOCIAL SECURITY NUMBER <b>577-26-3457</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>69</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>APR. 18, 1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>CALVERT MEMORIAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>PRINCE FREDERICK, MD.</b>		9c. COUNTY OF DEATH <b>CALVERT</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S COUNTY</b>		10c. CITY, TOWN OR LOCATION <b>LEXINGTON PARK</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>RT. 1, BOX 180-G</b>		10f. ZIP CODE <b>20653</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1942 - 1943</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5TH. GRADE</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TRUCK DRIVER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNION</b>	
17. FATHER'S NAME (First, Middle, Last) <b>VIVIAN DENT</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAE GIBBONS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOAN MARIE DENT</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 1, BOX 180-G, LEXINGTON PARK, MD. 20653</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHARLES MEMORIAL GARDENS 8/07/91</b>		20c. LOCATION — City or Town, State <b>LEONARDTOWN, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MARYLAND 20650</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIORESPIRATORY ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. ANOXIC BRAIN DEATH</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. ADULT RESPIRATORY DISTRESS SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. PNEUMONIA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D 29821</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES DAMALOUJI, M.D. PRINCE FREDERICK, MD. 20678</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 12 '91</b>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital for the attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SAMUEL WARREN DODSON</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>14</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>279-45-2511</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>46</b> YRS.		7. DATE OF BIRTH MONTH <b>2</b> DAY <b>26</b> YEAR <b>45</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING, MD</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>PG Prince George</b>		10c. CITY, TOWN OR LOCATION <b>BELTSVILLE (Beltsville)</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7800 OLD MURKIRK RD</b>				10f. ZIP CODE <b>20705</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12 Grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Correctional Officer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dist Of Columbia</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William P. Dodson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bernice S. Ross</b>			
19a. INFORMANT'S NAME (Type/Print) <b>(Mother) Mrs Bernice S. Dodson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7800 Old Murkirk Rd, Beltsville, Md 20705</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Queen's Chapel Church Cem.</b>		20c. LOCATION — City or Town, State <b>Beltsville, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George R. Snowden</i>				22. NAME AND ADDRESS OF FACILITY <b>SNOWDEN FUNERAL HOME P.A. 20850 246 N. Washington St. Rockville, Md</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Adeno Carcinoma of Stomach</b> DUE TO (OR AS A CONSEQUENCE OF): <b>METASTATIC ADENO CARCINOMA OF STOMACH</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>METASTATIC ADENO CARCINOMA OF STOMACH</b> DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <b>3 mos.</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.     						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. L. ... M.D.</i>		29c. LICENSE NUMBER	
29d. SIGNATURE AND TITLE OF CERTIFIER <i>Ronald C. Wheeler</i>				29e. DATE SIGNED (Month, Day, Year) <b>8-15-91</b>		29f. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ronald C. Wheeler 6107 Old Branch Ave Temple Hills MD 20725</b>	
31. DATE FILED (Month, Day, Year) <b>AUG 16 '91</b>		32. REGISTRAR'S SIGNATURE <i>Gelia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23659

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN DeVITA Helen C. DeVita</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>14</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:40</b> P M	
4. SOCIAL SECURITY NUMBER <b>150-36-7532</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-2-04</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Brooke Grove Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Olney</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Olney</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>18430 Brooke Grove Road</b>				10f. ZIP CODE <b>20832</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>Spain</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Librarian</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Library</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Afonso DeVita</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Juanita Lopez</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joyce Daly</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4509 Oak Hill Road; Rockville, Maryland 20853</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Suburban Crematory</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>B. Ch...</b> M00827				22. NAME AND ADDRESS OF FACILITY <b>Ramp Funeral Services, P.A. 933 Gist Avenue; Silver Spring, Md. 20910</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral infarct -</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Multiple cerebral infarcts</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>5 days</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's Dementia.</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25b. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James Roun MD</b>				29c. LICENSE NUMBER <b>D 37495</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/14/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James Roun MD 11910 Ashley Dr. Rockville MD 20852</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 15 '91</b>				32. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23660

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MILDRED DODD</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:35</b> M	
4. SOCIAL SECURITY NUMBER <b>577-60-1876</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 31, 1903</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Shady Grove Adventist Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rockville</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>---</b>				10b. COUNTY <b>---</b>		10c. CITY, TOWN OR LOCATION <b>Washington, D.C.</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>6224 - 30th Street, N.W.</b>			
10f. ZIP CODE <b>20015</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		17. KIND OF BUSINESS/INDUSTRY <b>US Treasury Dept.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Jacob Steiger</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Matilda Gotthardt</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John A. Patterson, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6224-30th Street, NW, Washington, D.C. 20015</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rock Creek Cemetery 8/16</b>		20c. LOCATION — City or Town, State <b>Washington, DC</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael S. Nelson</i>				22. NAME AND ADDRESS OF FACILITY <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisconsin Ave, NW, Washington, DC 20016</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Possible Drosepsis</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>chronic vegetative state</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Congestive heart failure</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's disease</b> <b>Renal failure</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Chelan MD</i>				29c. LICENSE NUMBER <b>D-33224</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. Chelan MD 50W Edmonston Dr #504, Rockville MD 20852</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Rodell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23661

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THELMA M. DEMMA				2. DATE OF DEATH MONTH DAY YEAR AUGUST 17, 1991				3. TIME OF DEATH 1:20 A M					
4. SOCIAL SECURITY NUMBER 214-42-2928				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) JUNE 23, 1904		8. BIRTHPLACE (State or Foreign Country) WASHINGTON, D.C.			
9a. FACILITY NAME (If not institution, give street and number) SPRINGBROOK ARTIST NURSING HOME						9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING				9c. COUNTY OF DEATH MONTGOMERY			
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 10000 BRUNSWICK AVENUE #422						10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CLERK				18b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT					
17. FATHER'S NAME (First, Middle, Last) JOSEPH P. GATELY						18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY C. CAMPBELL							
19a. INFORMANT'S NAME (Type/Print) MARGARET L. DINGLER (DAUGHTER)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 CROSBY ROAD HYATTSVILLE, MARYLAND 20783							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. OLIVET CEMETERY 8/20				20c. LOCATION — City or Town, State WASHINGTON, D.C.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD, 20901									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Coronary atherosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>One no vascular accident</i>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER D08046		29d. DATE SIGNED (Month, Day, Year) 8-19-91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John T. Baker 8218 Wisconsin Ave N.W.</i>													
31. DATE FILED (Month, Day, Year) AUG 20 '91				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23662

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PAULINE S. DEFFERT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Aug. 16 1991</b>		3. TIME OF DEATH <b>1:30 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>413-01-6150A</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 31, 1911</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Holy cross Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1018 Cresthaven Drive</b>				10f. ZIP CODE <b>20903</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Beautician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Alexander</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Baughard</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joan Fleming</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>720 Live Oak Dr., El Paso, Texas 79932</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 8-20-91</b>		20c. LOCATION — City or Town, State <b>Brentwood, MD.</b>		22. NAME AND ADDRESS OF FACILITY <b>Hines/Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David L. Hines</i>				22. NAME AND ADDRESS OF FACILITY <b>Hines/Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Brain Stem Infarction</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. <b>CHRONIC ARTERITIS</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death <b>7 Days</b> <b>6 weeks</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John A. Galano, M.D.</i>				29c. LICENSE NUMBER <b>D11921</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/16/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) <b>John A. Galano, M.D. 5225 Poole Mill Road, #1 Baltimore, Maryland 20814</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 19 '91</b>		32. REGISTRAR'S SIGNATURE <i>John A. Galano</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

91 23663

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>ROSE ETHEL DOWNING</u>				2. DATE OF DEATH MONTH <u>9</u> - DAY <u>21</u> - YEAR <u>91</u>		3. TIME OF DEATH <u>9:03A</u> M	
4. SOCIAL SECURITY NUMBER <u>112-260-783</u>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>98</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>Sept. 10, 1892</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Washington County Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Hagerstown</u>	
9c. COUNTY OF DEATH <u>Washington</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Washington</u>	
10c. CITY, TOWN OR LOCATION <u>Hagerstown</u>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>12 South Walnut Street</u>	
10f. ZIP CODE <u>21740</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u></u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Homemaker</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Own Home</u>	
17. FATHER'S NAME (First, Middle, Last) <u>William Grayson Furry</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Elizabeth Hull</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Vernon W. Furry</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1316 Gittings Avenue, Baltimore, Md. 21239</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Rose Hill Cemetery</u> DATE <u>8-24-91</u>		20c. LOCATION — City or Town, State <u>Clear Spring, Wash., Md.</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>R. Noel Brady</u>				22. NAME AND ADDRESS OF FACILITY <u>Andrew K. Coffman Funeral Home, Inc.</u> <u>40 E. Antietam St., Hagerstown, Md. 21740</u>			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiac arrest</u>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. <u>Acute myocardial infarction</u> DUE TO (OR AS A CONSEQUENCE OF): <u>5m</u>							
b. <u>Coronary atherosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): <u>2 day</u>							
c. <u>Generalized atherosclerosis</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Unknown</u>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Arteriosclerosis</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation a <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <u></u>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>L L PACIKER Jr MD</u>				29c. LICENSE NUMBER <u>D-09930</u>		29d. DATE SIGNED (Month, Day, Year) <u>9/21/91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>L L PACIKER Jr MD, 145 W. Washington St Hagerstown, MD</u>							
31. DATE FILED (Month, Day, Year) <u>AUG 23 '91</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

739-1444/ DOD 516 8/21/91 10/17/91

TO THE PHYSICIAN OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





12

91 23664

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>EVERETT DEVELDE</b>		2. DATE OF DEATH MONTH <b>08</b> DAY <b>20</b> YEAR <b>91</b>		3. TIME OF DEATH <b>06:55p</b>
4. SOCIAL SECURITY NUMBER <b>149 30 8023</b>	5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>85yrs</b>	7. DATE OF BIRTH (Month, Day, Year) <b>05/19/06</b>	8. BIRTHPLACE (State or Foreign Country) <b>Illinois</b>
9a. FACILITY NAME (If not institution, give street and number) <b>GBMC 6701 NORTH CHARLES ST</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Fallston</b>
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2503 ROY TERRACE</b>		
10f. ZIP CODE <b>21047</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>		
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clergy</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Ministry</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Harry S. DeVelde</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Frances Anna Smith</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Mary-Louisa DeVelde</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2503 Roy Terrace, Fallston, Md. 21047</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Specify cemetery, crematory or other place) <b>Cemetery Centre Presbyterian Church 8-24-91 New Park, Pa.</b>		20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>		22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Intercardiac conduction disease</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James H. Giddens MD</i>		29c. LICENSE NUMBER <b>015561</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/25/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Benjamin G. Charles H. Balto, MD 21002</b>				
31. DATE FILED (Month, Day, Year) <b>AUG 21 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23665

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALBERT JOHN EATON</b>				2. DATE OF DEATH MONTH <b>AUG</b> DAY <b>23</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1255</b> <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>001-14-7809</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 28, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NEW HAMPSHIRE</b>				9a. FACILITY NAME (If not institution, give street and number) <b>NAVAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>PATUXENT RIVER</b>	
9c. COUNTY OF DEATH <b>ST MARY'S</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S</b>	
10c. CITY, TOWN OR LOCATION <b>LEXINGTON PARK</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>P.O. BOX 112</b>	
10f. ZIP CODE <b>20653</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CHIEF QUALITY CONTROL</b>		16b. KIND OF BUSINESS/INDUSTRY <b>CIVIL SERVICE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ALBERT E. EATON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA GEORGE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. MARJORIE C. EATON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 112, LEXINGTON PARK, MARYLAND 20653</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>AUBURN CEMETERY</b>		20c. LOCATION — City or Town, State <b>AUBURN, NEW HAMPSHIRE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward W. Brinsfield</i>				22. NAME AND ADDRESS OF FACILITY <b>BRINSFIELD FUNERAL HOME, P.A. P.O. BOX 279, LEONARDTOWN, MD. 20650</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac failure</i>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <i>electromechanical dissociation</i> b. <i>Massive myocardial infarction</i> c. <i>ASCAD</i> d. <i>ASCAD</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus; Hypertension</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>cleared.</i>				25. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <i>Aug 23, 91</i>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Home</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Norval A. Rios, M.D.</i>				29c. LICENSE NUMBER <b>0101039901 VA.</b>		29d. DATE SIGNED (Month, Day, Year) <b>Aug 23, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NORVAL A. RIOS, M.D.</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 26 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julie Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23666

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Emma Edna Evans</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0255 AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-48-8777</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb. 15, 1904</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington, D.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Bethesda</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>4609 Harling Lane</b>	
10f. ZIP CODE <b>20814</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (14 or 5+) <b>College (14 or 5+)</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edward Lee Thompson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minnie Ellen Rothwell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edward L. Evans, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10503 Parkwood Drive, Kensington, Maryland 20895</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE <b>Cedar Hill Cemetery 8-16-91</b> <b>Suitland, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Will E. Boerj</b> M00672				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Asystole</b> DUE TO (OR AS A CONSEQUENCE OF): <b>immediate</b>							
b. <b>Heart Block &amp; Atrial Fibrillation</b> DUE TO (OR AS A CONSEQUENCE OF): <b>~ 1 1/2 week</b>							
c. <b>Myocardial Collapse, probable Myocardial Ischemic Damage</b> DUE TO (OR AS A CONSEQUENCE OF): <b>"</b>							
d. <b>Illness Stress &amp; Weakened heart</b> DUE TO (OR AS A CONSEQUENCE OF): <b>chronic</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide							
28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>							
28b. TIME OF INJURY <b>N/A</b>							
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
28d. DESCRIBE NOW INJURY OCCURED <b>N/A</b>							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>N/A</b>							
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>N/A</b>							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>J. R. Thistlethwaite, M.D.</b>							
29c. LICENSE NUMBER <b>D13399</b>							
29d. DATE SIGNED (Month, Day, Year) <b>8-13-91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. Richard Thistlethwaite, M.D. 10401 Old Georgetown Road, Bethesda, MD 20814</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 15 '91</b>							
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodale</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


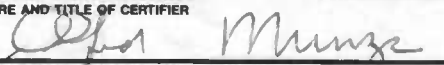
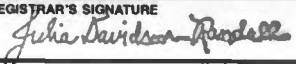
100-100-100



91 23667

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOHN ROBERT ELLIOTT				2. DATE OF DEATH MONTH DAY YEAR AUGUST 13, 1991		3. TIME OF DEATH 11:35 P M	
4. SOCIAL SECURITY NUMBER 242-20-8070		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) Apr 20, 1925	
8. BIRTHPLACE (State or Foreign Country) North Carolina				9a. FACILITY NAME (If not institution, give street and number) 819 Gist Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 819 Gist Avenue	
10f. ZIP CODE 20910				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Army, WWII				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 College (1-4 or 5+) 7				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tree Surgeon		16b. KIND OF BUSINESS/INDUSTRY Tree Service	
17. FATHER'S NAME (First, Middle, Last) Clarence Wilson Elliott				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Alexandria Lawing			
19a. INFORMANT'S NAME (Type/Print) Louise Elizabeth DerYoung				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12305 Featherwood Dr, Silver Spring, MD 20904			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory		20c. LOCATION — City or Town, State Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0827				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Bronchogenic Carcinoma DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 3 hours 12 mos						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)						28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.						29c. LICENSE NUMBER D12582	
29d. DATE SIGNED (Month, Day, Year) August 14, 1991						30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alfred Munzer, M.D. WAH 7600 Carroll Ave, Takoma Park, MD 20912	
31. DATE FILED (Month, Day, Year) AUG 15 '91						32. REGISTRAR'S SIGNATURE 	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23668

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lucille May Edmonds</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>18</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9 P M</b>			
4. SOCIAL SECURITY NUMBER <b>217-34-0194</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MARCH 1, 1912</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HOLY CROSS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SILVER SPRING</b>				9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>SILVER SPRING</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <b>1806 BRISBANE STREET</b>				10f. ZIP CODE <b>20902</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>11</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY					
17. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Whitfield WHITNEY SHORT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BESSIE WORSHAM</b>					
19a. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>JOSEPH S. EDMONDS (SON) 4400 NORTH 11TH STREET ARLINGTON, VIRGINIA 22201</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4400 NORTH 11TH STREET ARLINGTON, VIRGINIA 22201</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GEORGE WASHINGTON CEMETERY 8/21</b>		20c. LOCATION — City or Town, State <b>ADELPHI, MARYLAND</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Francis J. Collins</b>			
22. NAME AND ADDRESS OF FACILITY <b>FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Cardiorespiratory Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Acute Aspiration Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Acute U-T-T = Urinary Tract Infection</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Atrial Fibrillation with Rapid Ventricular Response</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined							
28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>G B Patrick MD</b>							
29c. LICENSE NUMBER <b>D17729</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/18/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G B Patrick MD 9221 Coleridge Rd SS, Md 20910</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 20 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodriguez</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23669

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Irene Edith ENGRAM</b>				2. DATE OF DEATH <b>August 17, 1991</b>				3. TIME OF DEATH <b>9:10 A</b>	
4. SOCIAL SECURITY NUMBER <b>024-12-1566</b>		5. SEX <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH <b>08/20/24</b>		8. BIRTHPLACE (State or Foreign Country) <b>Waltham, Mass.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Doctors Community Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham</b>				9c. COUNTY OF DEATH <b>Prince George's</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Berwyn Heights</b>				10d. INSIDE CITY LIMITS? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
10e. STREET AND NUMBER <b>5801 Pontiac Street</b>				10f. ZIP CODE <b>20740</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Account Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>University of Maryland</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Ernest Richard Pope</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith May Bowery</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Father Tom Engram</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5801 Pontiac Street, Berwyn Heights, MD 20740</b>					
20a. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Lincoln Cemetery 8/14/91</b>				20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSE <i>Mark A. Brown</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiopulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Cerebral Anoxia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Advance Degenerative Disease of Brain</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>d.</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> <b>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>				27. MANNER OF DEATH <b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b>					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Karim MD</b>				29c. LICENSE NUMBER <b>D-18895</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-11-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 16 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as required by the funeral director's permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23670

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Virginia Barrett Elliman				2. DATE OF DEATH MONTH DAY YEAR August 17, 1991		3. TIME OF DEATH 4:15 P M	
4. SOCIAL SECURITY NUMBER 579-44-5357		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	7. DATE OF BIRTH (Month, Day, Year) Nov. 10, 1904		8. BIRTHPLACE (State or Foreign Country) Illinois	
9a. FACILITY NAME (If not institution, give street and number) 15425 Bramblewood Drive				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 15425 Bramblewood Drive				10f. ZIP CODE 20906		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse		16b. KIND OF BUSINESS/INDUSTRY American Red Cross			
17. FATHER'S NAME (First, Middle, Last) Thomas Evans Elliman				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Barden Barrett			
19a. INFORMANT'S NAME (Type/Print) Juliet France				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15425 Bramblewood Drive, Silver Spring, MD 20906			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Suburban Crematory		20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Eileen H. Rapp				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive Pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death year.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Bran [Signature]				29c. LICENSE NUMBER Md. 20832		29d. DATE SIGNED (Month, Day, Year) 8/17/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bran [Signature] Ch. # T14, Olney, Md. 20832 B.A. Viewman, MD							
31. DATE FILED (Month, Day, Year) AUG 19 '91				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23671

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jean Arlene Eshelman</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 18, 1991</b>		3. TIME OF DEATH <b>9:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>220-28-7822</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>57</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 23, 1934</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>16 Linbar Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>16 Linbar Drive</b>			
10f. ZIP CODE <b>21740</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>liquor store</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Reed Rickard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lot Lanford</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Harold M. Eshelman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16 Linbar Dr., Hagerstown, Md. 21740</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		20c. LOCATION — City or Town, State <b>Hagerstown, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott Munnich</i>				22. NAME AND ADDRESS OF FACILITY <b>MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Coronary Occlusion</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>atherosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>24h</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert M. Campbell MD</i>				29c. LICENSE NUMBER <b>201606</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/19/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print) <i>Robert M. Campbell MD Hagerstown MD</i>							
31. DATE FILED (Month, Day, Year) <b>AUG 21 '91</b>				32. REGISTRAR'S SIGNATURE (Type/Print) <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11/15/55



ITEMS:23 thru 28f per ME  
G-679 9/20/91 cm  
91-4661-003

91-161

91 23672

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Donald Wayne EDWARDS, Jr. <i>Donald Wayne Edwards</i>				2. DATE OF DEATH MONTH DAY YEAR 08 15 1991		3. TIME OF DEATH 8:30 A M					
4. SOCIAL SECURITY NUMBER 215 90 4682		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 16 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-7-1975		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) Franklin Manor Beach				9b. CITY, TOWN OR LOCATION OF DEATH Churchton			9c. COUNTY OF DEATH Anne Arundel				
10a. STATE MD				10b. COUNTY A.A.		10c. CITY, TOWN OR LOCATION Churchton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1235 Fairfax Ave.				10f. ZIP CODE 20733		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) student		16b. KIND OF BUSINESS/INDUSTRY —							
17. FATHER'S NAME (First, Middle, Last) Donald Wayne Edwards, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Phoebe Wendell							
19a. INFORMANT'S NAME (Type/Print) Donald Wayne Edwards, Sr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1235 Fairfax Ave., Churchton, MD 20733							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakemont Mem. Gardens 8-20-91		20c. LOCATION — City or Town, State Davidsonville, (AA) MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald Wayne Edwards</i>				22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, Owings, MD 20736							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DROWNING DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 08 15 1991		28b. TIME OF INJURY 8:30A		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) WATER				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) FOUND: FRANKLIN MANOR BEACH, ANNE ARUNDEL CO., MD					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 08 16 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD DCME 111 Penn Street, Baltimore Maryland 21201											
31. DATE FILED (Month, Day, Year) AUG 23 1991											

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be associated within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the medical examiner and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEMS: 23, 27 per ME  
G-679 9/6/91 cm  
91-4575-031

91 23673

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>George Ernest Fellows</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 09 1991</b>		3. TIME OF DEATH <b>6:05 A M</b>	
4. SOCIAL SECURITY NUMBER -----		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN. <b>6</b>		7. DATE OF BIRTH (Month, Day, Year) <b>July 3, 1991</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>Beltsville</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>11382 Cherry Hill Rd., #202</b>				10f. ZIP CODE <b>20705</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>0 years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) -----		16b. KIND OF BUSINESS/INDUSTRY -----			
17. FATHER'S NAME (First, Middle, Last) <b>George Ernest Fellows, III</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Monica M. Davis</b>			
19a. INFORMANT'S NAME (Type/Print) <b>George Ernest Fellows, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5022 Paducah Road College Park, Md. 20740</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery 8/13/91</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald V. Borgwardt</b>				22. NAME AND ADDRESS OF FACILITY <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SUDDEN INFANT DEATH SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED _____ _____				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____ _____			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>A M Dixon</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 10 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Am Dixon 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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F.E.H.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) aka MICHELE R. FILLING-KATZ MICHELE R. KATZ				2. DATE OF DEATH MONTH 8 DAY 11 YEAR 1991		3. TIME OF DEATH 13:30 P M	
4. SOCIAL SECURITY NUMBER 216-60-2774		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-23-1955	
9a. FACILITY NAME (If not institution, give street and number) 3020 BROWN STONE COURT				9b. CITY, TOWN OR LOCATION OF DEATH BURTONSVILLE		9c. COUNTY OF DEATH MONTGOMERY CO.	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BURTONSVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3020 BROWN STONE COURT				10f. ZIP CODE 20866		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1980-86		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) GENETIC NEUROLOGIST		16b. KIND OF BUSINESS/INDUSTRY N.I.H.			
17. FATHER'S NAME (First, Middle, Last) RAYMOND W. FILLING, JR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) DORIS L. LOPER			
19a. INFORMANT'S NAME (Type/Print) MARGOT NELSON (SISTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24981 NEWBERRY DRIVE NOVI, MICHIGAN 48375			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY 8/15		20c. LOCATION — City or Town, State ALEXANDRIA, VIRGINIA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL.SPR., MD. 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Gunshot Wound (2) of head & Rt. Arm Gunshot Wounds (2) of Head and Right Arm DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND 8-11-91		28b. TIME OF INJURY UNK M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3020 BROWN STONE CT.			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]			
29c. LICENSE NUMBER O. C. M. E.				29d. DATE SIGNED (Month, Day, Year) 08-12-1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) AUG 16 '91				32. REGISTRAR'S SIGNATURE [Signature]			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL AT THE TIME OF DEATH: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23675

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) JOSEPH WILLIAM FORBES				2. DATE OF DEATH MONTH DAY YEAR AUGUST 25, 1991		3. TIME OF DEATH 9:58 P.M. M	
4. SOCIAL SECURITY NUMBER 214-30-4488		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 24, 1930	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) ST. MARY'S NURSING CENTER		9b. CITY, TOWN OR LOCATION OF DEATH LEONARDTOWN	
9c. COUNTY OF DEATH ST. MARY'S				10a. STATE MARYLAND		10b. COUNTY ST. MARY'S	
10c. CITY, TOWN OR LOCATION MECHANICSVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4110 CHAPTICO-MECHANICSVILLE ROAD	
10f. ZIP CODE 20659				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRUCK DRIVER		16b. KIND OF BUSINESS/INDUSTRY FURNITURE STORE	
17. FATHER'S NAME (First, Middle, Last) RICHARD E. FORBES				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE HANCE			
19a. INFORMANT'S NAME (Type/Print) ETHEL ELIZABETH FORBES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4110 CHAPTICO-MECHANICSVILLE RD., MECHANICSVILLE, MD. 20659			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) QUEEN OF PEACE		20c. LOCATION — City or Town, State 8/30 HELEN, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward M. Brown</i>				22. NAME AND ADDRESS OF FACILITY BRINSFIELD FUNERAL HOME, P.A. P.O. BOX 279, LEONARDTOWN, MARYLAND 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Rheumatoid arthritis</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James C. Boyd</i>				29c. LICENSE NUMBER D19917		29d. DATE SIGNED (Month, Day, Year) 8-28-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMES C. BOYD, M.D., 17 JEFFERSON STREET, LEONARDTOWN, MARYLAND 20650							
31. DATE FILED (Month, Day, Year) AUG 29 '91				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23676

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LINDA RUTH FALLON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 11, 1991</b>		3. TIME OF DEATH HOUR MIN. SEC. <b>6:59p M</b>	
4. SOCIAL SECURITY NUMBER <b>559-90-9726</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>39 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>8/11/52</b>	
8. BIRTHPLACE (State or Foreign Country) <b>CALIFORNIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>NIH, THE CLINICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA,</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>W. VIRGINIA</b>		10b. COUNTY <b>MORGAN</b>	
10c. CITY, TOWN OR LOCATION <b>BERKELEY SPRING</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>402 EWING STREET</b>	
10f. ZIP CODE <b>25411</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>5 YRS.</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COUNSELOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>COUNSELING</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JAMES EARL MITCHELL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GLORIA VIOLA DORNEY MITCHELL</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOSEPH FALLON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>402 EWING ST, BERKELEY SPRING, WEST VIRGINIA 25411</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Suburban Crematory</b>		20c. LOCATION — City or Town, State <b>Silver Spring, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J.P. Marshall</i>				22. NAME AND ADDRESS OF FACILITY <b>Marshall's Funeral Home, Inc 4217 9th Street, NW Washington, DC 20011</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ACUTE RIGHT VENTRICULAR FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. PULMONARY TUMOR MICROEMBOLI</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. ADENOCARCINOMA OF THE BREAST</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>24a. WAS AN AUTOPSY PERFORMED?</b> 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b> 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R. Cunnion MD ATTENDING PHYSICIAN</b>				29c. LICENSE NUMBER <b>D29484</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUG 13, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ROBERT E. CUNNION MD, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

NO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital, attending physician, or funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be delivered for filing to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23677

Dorothy Burwell Feigley

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DOROTHY B. FEIGLEY</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>21</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:23 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>234-38-9203</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 6, 1922</b>	
8. BIRTHPLACE (State or Foreign Country) <b>W. Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>	
9c. COUNTY OF DEATH <b>Washington</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>	
10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>55 Randolph Avenue</b>	
10f. ZIP CODE <b>21740</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+) <b>blueprint room</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Fairchild</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Nathanael Burwell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Loraine Turner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Clarence H. Feigley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>55 Randolph Avenue Hagerstown, Maryland 21740</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery 8/23</b>		20c. LOCATION — City or Town, State <b>Hagerstown, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald N. Minnich</i>				22. NAME AND ADDRESS OF FACILITY <b>Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cerebrovascular accident</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Atherosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Adult-onset Diabetes</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>d.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>24a. WAS AN AUTOPSY PERFORMED?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Manzar Shafi</i>				29c. LICENSE NUMBER <b>D28365</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/21/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Manzar Shafi 368 Mill Street Hagerstown, Maryland 21740</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 23 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23678

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Samuel Clinton Furr</i>				2. DATE OF DEATH MONTH <i>8</i> DAY <i>18</i> YEAR <i>91</i>		3. TIME OF DEATH <i>5:15 P M</i>	
4. SOCIAL SECURITY NUMBER <i>214-12-6953</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>70</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>4-15-21</i>	
9a. FATHER'S NAME (If not institution, give street and number) <i>1205 Peohantas Ave</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Salisbury, Md.</i>		9c. COUNTY OF DEATH <i>Wilcomine</i>	
10a. STATE <i>Md.</i>		10b. COUNTY <i>Wilcomine</i>		10c. CITY, TOWN OR LOCATION <i>Salisbury</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1205 Peohantas Ave</i>				10f. ZIP CODE <i>21801</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Blk</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>C &amp; P Telephone</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Storekeeper / C &amp; P Telephone Co.</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Samuel B. Furr</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Hester Dashiell Furr</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Clara Sample</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>RFD #4 Box 420 Delmar Md. 21875</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Dealah Vet. Cem.</i>		20c. LOCATION — City or Town, State <i>Hurlock, Md.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <i>WATSON Funeral Home West Rd. Salisbury, Md. 21801</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Squamous Cell Carcinoma of Tongue</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Squamous Cell Carcinoma of Neck</i> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <i>2 YEARS</i> <i>4 MONTHS</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>James R. Gaul</i>		29c. LICENSE NUMBER <i>D 35485</i>		29d. DATE SIGNED (Month/Day/Year) <i>8/20/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JAMES R. GAUL, M.D., 106 PINE BLUFF RD, SALISBURY, MD</i>							
31. DATE FILED (Month, Day, Year) <i>Aug 20 91</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: Another certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1975-80





DHMH-18 Rev 1/89



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Germaine Ford				2. DATE OF DEATH MONTH DAY YEAR 08 13 91		3. TIME OF DEATH 1845 M	
4. SOCIAL SECURITY NUMBER 185-20-2303		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 9, 1912 PA	
8a. FACILITY NAME (If not institution, give street and number) Union Hospital				8b. CITY, TOWN OR LOCATION OF DEATH Elkton, MD		8c. COUNTY OF DEATH MD	
10a. STATE MD		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION North East		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 30 Walbeck Lane				10f. ZIP CODE 21901		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Office Manager		16b. KIND OF BUSINESS/INDUSTRY Medical			
17. FATHER'S NAME (First, Middle, Last) Harry G.D. Carr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ella Yates			
19a. INFORMANT'S NAME (Type/Print) Germaine Walbeck				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Walbeck Lane, North East, MD 21901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Birmingham-Lafayette		20c. LOCATION — City or Town, State Chadds Ford, PA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Edward McKee				22. NAME AND ADDRESS OF FACILITY Gee Funeral Home 259 E. Main St., Elkton, MD 21921			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ruptured Abdominal Aortic Aneurysm Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Atherosclerosis c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Behnders		29c. LICENSE NUMBER D23322		29d. DATE SIGNED (Month, Day, Year) 8/14/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) AUG 14 '91		32. REGISTRAR'S SIGNATURE Julia Davidson-Pondell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23682

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KENNETH R. GILLESPIE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8 13 91</b>		3. TIME OF DEATH <b>12:26am</b>	
4. SOCIAL SECURITY NUMBER <b>528-01-7114</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/13/04</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TAKOMA PARK</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY <b>PRINCE GEORGES</b>		10c. CITY, TOWN OR LOCATION <b>TAKOMA PARK</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6714 CONWAY AVE</b>				10f. ZIP CODE <b>20912</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>PROOF READER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PROOF READER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>G.P.O.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JAMES GILLESPIE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HANNAH J. WILLIAMS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WANDA M. GILLESPIE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6714 CONWAY AVE. TAKOMA PARK, MD 20912</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FT. LINCOLN CEMETERY - 8/16/91 BRENTWOOD MD.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael J. Byler</i>				22. NAME AND ADDRESS OF FACILITY <b>TAKOMA FUNERAL HOME, INC. 254 Carroll St. N.W., Washington, D.C.</b>			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary failure</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Cardiac Arrhythmia</b> b. <b>Left embolism</b> c. <b>Malignant lymphoma</b> d. <b>Malignant lymphoma</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Clara Chan, M.D.</i>				29c. LICENSE NUMBER <b>D41828</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/13/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CLARA CHAN, M.D. 7525 GREENWAY CENTER DR.</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Rodell</i> <b>GREENBELT, MD 20770</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) JOHN <u>Ralph</u> <u>Guy</u>				2. DATE OF DEATH MONTH <u>8</u> DAY <u>15</u> YEAR <u>91</u>		3. TIME OF DEATH <u>11:40</u> A M					
4. SOCIAL SECURITY NUMBER <u>217-76-5363</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>74</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>DEC. 22, 1916</u>		8. BIRTHPLACE (State or Foreign Country) <u>MARYLAND</u>			
9a. FACILITY NAME (If not institution, give street and number) <u>LIBERTY MEDICAL CENTER</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u>			9c. COUNTY OF DEATH <u>BALTIMORE</u>				
10a. STATE <u>MARYLAND</u>				10b. COUNTY <u>ST. MARY'S COUNTY</u>		10c. CITY, TOWN OR LOCATION <u>HELEN</u>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <u>GENERAL DELIVERY</u>				10f. ZIP CODE <u>20635</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>6TH. GRADE</u> College (1-4 or 5+) <u>LABORER</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>LABORER</u>		16b. KIND OF BUSINESS/INDUSTRY <u>REHABILITATION</u>					
17. FATHER'S NAME (First, Middle, Last) <u>JAMES FRANCIS GUY</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>FLORENCE G. LATHAM</u>							
19a. INFORMANT'S NAME (Type/Print) <u>HELEN G. LATHAM</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>GENERAL DELIVERY, HELEN, MARYLAND 20635</u>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>CHARLES MEMORIAL GARDENS 8/20/91</u>		DATE <u>8/20/91</u>		20c. LOCATION — City or Town, State <u>LEONARDTOWN, MARYLAND</u>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Michael L. Gardiner</u>				22. NAME AND ADDRESS OF FACILITY <u>MATTINGLEY-GARDINER FUNERAL HOME, P.A.</u> <u>P.O. BOX 270, LEONARDTOWN, MD. 20650</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Sepsis.</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST } b. <u>pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Renal insufficiency.</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Michael K. RO MD LMC</u>				29c. LICENSE NUMBER <u>D39297</u>			29d. DATE SIGNED (Month, Day, Year) <u>8/15/91</u>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>MICHAEL K RO MD LMC</u>											
31. DATE FILED (Month, Day, Year) <u>AUG 20 1991</u>		32. REGISTRAR'S SIGNATURE <u>Gina Davidson-Randall</u>									

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Betty H. Greene</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>17</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:43 PM</b>	
4. SOCIAL SECURITY NUMBER <b>577-22-1687</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last b-day) <b>94</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01-31-97</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Springbrook Adventist N.H.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10725 Kinloch Road</b>				10f. ZIP CODE <b>20903</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Elementary</b> College (1-4 or 5+) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>National Bank of Washington</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Johnson Hall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Dunn</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Doris G. McKay</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10725 Kinloch Road, Silver Spring, Md. 20906</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		20c. LOCATION — City or Town, State <b>Silver Spring, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Hines/Rinaldi Funeral Home</b> <b>11800 N.H. Ave., Silver Spring, Md. 20904</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Heart failure</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <b>CVA</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>2 days</b> <b>7 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>108089</b>		29d. DATE SIGNED (Month, Day, Year) <b>18 Aug 91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael E. Leibowitz, MD 11120 N.H. Ave., Silver Spring, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 19 '91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23685

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jean Lucy Greco				2. DATE OF DEATH MONTH <u>8</u> DAY <u>13</u> YEAR <u>91</u>		3. TIME OF DEATH <u>8 PM</u> M	
4. SOCIAL SECURITY NUMBER 138-07-2709		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 80 YRS.		7. DATE OF BIRTH (Month, Day, Year) 01/24/11	
8. BIRTHPLACE (State or Foreign Country) Long Island, NY				9a. FACILITY NAME (If not institution, give street and number) Prince George's General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Cheverly	
9c. COUNTY OF DEATH Prince George's				10a. STATE Maryland		10b. COUNTY Anne Arundel	
10c. CITY, TOWN OR LOCATION Laurel				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 5 Rose Street	
10f. ZIP CODE 20724		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>1 Year</u>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Own Home		17. FATHER'S NAME (First, Middle, Last) Gaetano Palazzotto	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Gaetana Candurra				19a. INFORMANT'S NAME (Type/Print) George Greco		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4437 Glen Rose Street, Fairfax, Virginia 22032	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Lincoln Cemetery 8/19/91		20c. LOCATION — City or Town, State Brentwood, Maryland		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>	
22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Arrhythmia</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death <u>Days</u>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>sustained hypertension with abdominal adhesions</u> <u>chronic pedal edema</u>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>	
29c. LICENSE NUMBER D22780				29d. DATE SIGNED (Month, Day, Year) 8/13/91		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JULIA DAVIDSON-RANDALL MD 7500 Greenway Cir Dr Greenbelt Md 20770	
31. DATE FILED (Month, Day, Year) AUG 16 '91		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ELSIE A. GERADA</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8-18-91</b>		3. TIME OF DEATH M <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>136-20-8568</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-18-09</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Lot 300- White Horse Park</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Berlin</b>		9c. COUNTY OF DEATH <b>Worcester</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Berlin</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Lot 300 - White Horse Park</b>				10f. ZIP CODE <b>21811</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>At Home</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>At Home</b>		16b. KIND OF BUSINESS/INDUSTRY <b>-----</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Frank Trappe</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Trappe</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Henry Albert</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1005 Clarke Ave. Pocomoke, Md., 21851</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>George Washington Memorial Park Paramus, N.J.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Ullrich</i>				22. NAME AND ADDRESS OF FACILITY <b>Ullrich Funeral Home Berlin, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARREST</b>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. <b>CARDIAC ARREST</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>CARDIAC ARTERIOSCLEROSIS</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>HYPERTENSION</b> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen F. Waters MD</i>				29c. LICENSE NUMBER <b>D27993</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-19-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stephen F. Waters, MD - 10th. St. &amp; Philadelphia Ave., Ocean City, Md. 21842</b>							
31. DATE FILED (Month, Day, Year) <b>10 AUG 19 91</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (Last, Middle, First) <b>GROSSNICKLE ELIZABETH</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>20</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0154 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-09-8353</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>82</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>March 8, 1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Washington County Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Hagerstown</b>		9c. COUNTY OF DEATH <b>Washington</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Hagerstown</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>27 E. Lincoln Ave.</b>				10f. ZIP CODE <b>21740</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>sales clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>department store</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John M. Frey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Flora Renner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Richard Motz</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 Clubhouse Dr., Hagerstown, Md. 21740</b>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rest Haven Cemetery</b>		20c. LOCATION — City or Town, State <b>Hagerstown, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Scott Mennick</b>				22. NAME AND ADDRESS OF FACILITY <b>MINNICH FUNERAL HOME</b> <b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Congestive Heart Failure</b>  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Non Insulin Dependant Diabetes mellitus</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Fatima M. Mohiuddin</b>		29c. LICENSE NUMBER <b>D38942</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/22/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FATIMA M. MOHIUDDIN 411 DIVISION AVE HAGERSTOWN MD 21740</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 23 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					



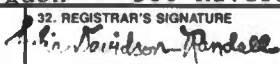




91 23688

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HERBERT HENRY</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>16</b> YEAR <b>91</b>				3. TIME OF DEATH <b>0345</b> <b>A</b>	
4. SOCIAL SECURITY NUMBER <b>218-16-5966</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-05-24</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD</b>		10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>HEBRON</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>BOX 778-A QUERCUS DR.</b>				10f. ZIP CODE <b>21830</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MINISTER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>MINISTRY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>RALPH (UNK) GLADDEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DELEA HORSEMAN GLADDEN</b>					
19a. INFORMANT'S NAME (Type/Print) <b>BETTY DeVAUGHN GLADDEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>BOX 778-A QUERCUS DR. HEBRON, MD 21830</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>8-19-91</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SPRINGHILL MEMORY GARDENS 8-19</b>		20c. LOCATION — City or Town, State <b>HEBRON, MARYLAND</b>		20d. DATE <b>8-19</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME 501 SNOW HILL RD. SALISBURY, MD 21801</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary artery disease</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <b>Low</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D-15089</b>		29d. DATE SIGNED (Month, Day, Year) <b>10/16/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Andrew J. Forgash 560 Riverside Dr. Slaisbury, MD 21801</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 16 91</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23689

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RICHARD ALBERT GALLIS</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>18</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1314</b> M	
4. SOCIAL SECURITY NUMBER <b>211-24-2649</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-1-35</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1001 N. DIVISION STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>	
9c. COUNTY OF DEATH <b>WICOMICO</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>WICOMICO</b>	
10c. CITY, TOWN OR LOCATION <b>SLAISBURY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1001 N. DIVISION STREET</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>NAVY</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Years</b> College (1-4 or 5+) <b>4 Years</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>TEACHING</b>	
17. FATHER'S NAME (First, Middle, Last) <b>LOUIS J. GALLIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY P. MARCINCIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROSEMARY B. GALLIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1001 N. DIVISION ST. SALISBURY, MD 21801</b>			
20a. METHOD OF DISPOSITION <b>8-21-91</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARSONS CEMETERY</b>		20c. LOCATION — City or Town, State <b>SALISBURY, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME</b> <b>501 SNOW HILL RD. SALISBURY, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of Lung with Metastases</b>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas C. Hill Jr. MD. Attending Physician</b>				29c. LICENSE NUMBER <b>D 08008</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/20/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THOMAS C. Hill Jr. 108 Pine Bluff Rd. Salisbury, Md 21801</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 20 '91</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17 0000

91 23690

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Joseph Hilliard				2. DATE OF DEATH MONTH DAY YEAR 08 13 91		3. TIME OF DEATH 8 PM	
4. SOCIAL SECURITY NUMBER 048-30-7227		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 51 YRS.	7. DATE OF BIRTH (Month, Day, Year) Dec. 3, 1939		8. BIRTHPLACE (State or Foreign Country) Connecticut	
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland				10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 2 Mercy Court		10f. ZIP CODE 20854	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer/Manager				16b. KIND OF BUSINESS/INDUSTRY IBM/technical		17. FATHER'S NAME (First, Middle, Last) William Hilliard	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Malloy				19a. INFORMANT'S NAME (Type/Print) Theresa Cain Hilliard		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mercy Court, Potomac, Maryland 20854	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Gabriel's Cemetery 8/17/91		20c. LOCATION — City or Town, State Potomac, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00689				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASPIRATION PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): b. GLIOBLASTOMA MULTIFORME DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death 6 HRS 1 YR							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James G. Brown MD				29c. LICENSE NUMBER 307185		29d. DATE SIGNED (Month, Day, Year) 8/12/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A. Brown, MD 14808 Physicians Lane Rockville, MD 20850							
31. DATE FILED (Month, Day, Year) AUG 15 '91				32. REGISTRAR'S SIGNATURE Julia Davidson-Rodriguez			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

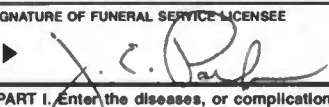
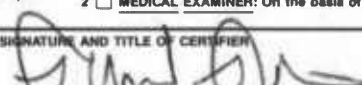
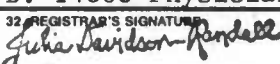
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23691

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Edwin David HOOFNAGLE				2. DATE OF DEATH MONTH DAY YEAR August 10, 1991		3. TIME OF DEATH 2:50 p. M	
4. SOCIAL SECURITY NUMBER 218-28-6112		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 22, 1930	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 11504 Flints Grove Lane		9b. CITY, TOWN OR LOCATION OF DEATH North Potomac	
9c. COUNTY OF DEATH Montgomery				10a. STATE Maryland		10b. COUNTY Montgomery	
10c. CITY, TOWN OR LOCATION North Potomac				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 11504 Flints Grove Lane	
10f. ZIP CODE 20878				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contract Consultant		16b. KIND OF BUSINESS/INDUSTRY Self Employed	
17. FATHER'S NAME (First, Middle, Last) Charles C. Hoofnagle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Jane Mc Cleaf			
19a. INFORMANT'S NAME (Type/Print) Hildegard W. Hoofnagle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as #10			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Oak Cemetery 8/14/91		20c. LOCATION — City or Town, State Gaithersburg, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  MO0896				22. NAME AND ADDRESS OF FACILITY De Vol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC PROSTATE CANCER Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Due to (or as a consequence of):						Approximate Interval Between Onset and Death 2 mo.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D29675		29d. DATE SIGNED (Month, Day, Year) August 12, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ralph V. Boccia, M.D. 14808 Physicians Lane #212 Rockville, Maryland 20850							
31. DATE FILED (Month, Day, Year) AUG 15 '91				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) <b>Judith A. Harkison</b>		2. DATE OF DEATH MONTH DAY YEAR <b>August 14, 1991</b>		3. TIME OF DEATH <b>10:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>186-28-6770</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>55</b> YRS.	
		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) <b>May 7, 1936</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>4932 Sentinel Dr. Apt. 304</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>		9c. COUNTY OF DEATH <b>Montgomery</b>
RESIDENCE OF DECEDENT					
10a. STATE <b>Md.</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Bethesda</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>4932 Sentinel Dr.</b>			10f. ZIP CODE <b>20816</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Editor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Smithsonian Magazine</b>	
17. FATHER'S NAME (First, Middle, Last) <b>J. Paul Harkison</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethyl Miller</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Richard Schugardt</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4932 Sentinel Dr. Apt. 304 Bethesda, Md. 20816</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rolling Green Memorial Park</b>		20c. LOCATION — City or Town, State <b>Lower Allentownship, Pa.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas S. Chambers</i> #670		22. NAME AND ADDRESS OF FACILITY <b>W.W.Chambers Co. Inc.</b> <b>5801 Cleveland Ave. Riverdale, Md. 20737</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Arrest</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>Metastatic Sarcoma</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  Approximate Interval Between Onset and Death <b>1 day</b> <b>3 years</b>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>D 33293</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/15/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FREDERICK P. SMITH, MD 5401 WESTERN AVE NW WASHINGTON DC 20007</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 16 '91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



91 23693

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jessie MacDonald Mabon Hilderbrand</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 15, 1991</b>		3. TIME OF DEATH <b>9:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>578-24-8829</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 3, 1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Scotland</b>				9. FACILITY NAME (If not institution, give street and number) <b>Suburban Hospital</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>	
11. RESIDENCE OF DECEDENT 10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Chevy Chase</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>5100 Dorset Avenue, #108</b>		10f. ZIP CODE <b>20815</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>President</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Banking Industry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John MacDonald Mabon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jean Bovaird</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Irene D. San Fellipo</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5511 Carolina Place, N.W., Washington, D.C. 20016</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park 8/20/91</b>		20c. LOCATION — City or Town, State <b>Rockville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Barbara J. McMullen Lawrence</b> M00381				22. NAME AND ADDRESS OF FACILITY <b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>MASSIVE CEREBROVASCULAR ACCIDENT</b> 3 DAYS							
b. <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> INDEF							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>FRACTURED LEFT HIP</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>7 5 91</b>		28b. TIME OF INJURY <b>P M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>FELL AT HOME</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>#10</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D07099</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/16/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANCIS C MAYLE 8200 WISCONSIN AVE BETHESDA MD 20814</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 19 '91</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Robert E. Hodson, Sr.				2. DATE OF DEATH MONTH DAY YEAR Aug. 12, 1991		3. TIME OF DEATH 11:50 P M	
4. SOCIAL SECURITY NUMBER 577-34-1846		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 26, 1908	
9a. FACILITY NAME (If not institution, give street and number) 6204 Stardust Lane				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6204 Stardust Lane				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lawyer		16b. KIND OF BUSINESS/INDUSTRY Private Firm			
17. FATHER'S NAME (First, Middle, Last) Robert Edward Hodson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lilian Fish			
19a. INFORMANT'S NAME (Type/Print) Phyllis B. Hodson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6204 Stardust La., Bethesda, MD 20817			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Comfort Crematory 8/14		20c. LOCATION — City or Town, State Alexandria, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael E. Nelson</i>				22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, DC 20016			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic adenocarcinoma of the prostate DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death 1 1/2 yrs.
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alison Martin</i>				29c. LICENSE NUMBER D39283		29d. DATE SIGNED (Month, Day, Year) Aug. 13, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alison Martin, M.D., 5401 Western Ave., NW, Washington, D.C. 20015							
31. DATE FILED (Month, Day, Year) AUG 14 '91		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 87

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Minnie Martin Haggerty</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4 38 P M</b>
4. SOCIAL SECURITY NUMBER <b>029 20 3809</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>50 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>10-12-10</b>
8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>		9. FACILITY NAME (If not institution, give street and number) <b>DOCTOR'S Community Hospital</b>		
9b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham</b>		9c. COUNTY OF DEATH <b>Prince George</b>		
10a. STATE <b>NY</b>	10b. COUNTY	10c. CITY, TOWN OR LOCATION <b>Long Island</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER <b>1071 Straight Path</b>		10f. ZIP CODE <b>10704</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PVT</b>		
17. FATHER'S NAME (First, Middle, Last) <b>John Lester</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lessie Martin</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Caroline Hagel</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>221 Marritt Ave. Long Island, NY 11798</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Church Cemetery, New York 8-16</b>		20c. LOCATION — City or Town, State <b>Pine Lawn, New York</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>J.B. Jenkins Funeral Home</b>		22. NAME AND ADDRESS OF FACILITY <b>7474 Landover Rd. Landover, MD 20785</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death <b>minutes</b> <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>NIA</b>		28b. TIME OF INJURY <b>M</b>
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Deputy Medical Examiner</b>		29c. LICENSE NUMBER <b>01852</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-11-91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL A. DEVORE, MD 4203 Queensbury Rd Hyattsville MD 20781</b>				
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>		32. REGISTRAR'S SIGNATURE <b>Gulie Davidson-Randall</b>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21219-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use of the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23696

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Dorothy Mae HARPER</b>				2. DATE OF DEATH MONTH <b>August</b> DAY <b>07</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>2:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>579-32-4305</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b>		IF UNDER 24 HRS. HOURS <b>00</b> MIN. <b>00</b>	
7. DATE OF BIRTH (Month, Day, Year) <b>1/27/24</b>				8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Doctors Community Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham</b>				9c. COUNTY OF DEATH <b>Prince George</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Calvert County</b>		10c. CITY, TOWN OR LOCATION <b>North Beach</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8924 Greenwood</b>				10f. ZIP CODE <b>20714</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12 yrs.</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor Dietary Dept. Hospital</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Walter Townsend</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Myrtle Wallace</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Fredrick Cunningham</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8924 Greenwood, North Beach, MD 20714</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		DATE <b>8/12/91</b>		20c. LOCATION — City or Town, State <b>Brentwood, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>T. Carver</b>				22. NAME AND ADDRESS OF FACILITY <b>Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPTICEMIA</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. DUE TO (OR AS A CONSEQUENCE OF): <b>ACUTE RENAL FAILURE</b></p> <p>b. DUE TO (OR AS A CONSEQUENCE OF): <b>CONGESTIVE HEART FAILURE</b></p> <p>c. DUE TO (OR AS A CONSEQUENCE OF): <b>PNEUMONIA</b></p> </div> </div>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COMA</b> <b>HYDROCEPHALUS</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>VP R. Attend. Physician</b>				29c. LICENSE NUMBER <b>019897</b>		29d. DATE SIGNED (Month, Day, Year) <b>8.8.91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>V. SINGH 7209A Hanover Parkway Greenbelt Md 20770</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 15 '91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit (Form 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM HILDERBRAND</b>		2. DATE OF DEATH MONTH <b>08</b> DAY <b>05</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1 20A</b> M
4. SOCIAL SECURITY NUMBER <b>082-03-7701</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>82</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>March 27, 1909</b>	8. BIRTHPLACE (State or Foreign Country) <b>unknown</b>
9a. FACILITY NAME (If not institution, give street and number) <b>PRINCE GEORGE'S HOSPITAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CHEVERLY</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>
RESIDENCE OF DECEDENT				
10a. STATE <b>Maryland</b>	10b. COUNTY <b>Prince Georges</b>	10c. CITY, TOWN OR LOCATION <b>Brentwood</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER <b>4142 Bunker Hill Rd. # 56</b>		10f. ZIP CODE <b>20772</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>unknown</b>		16b. KING OF BUSINESS/INDUSTRY <b>unknown</b>
17. FATHER'S NAME (First, Middle, Last) <b>unknown</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Andrew T. Buckler</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number; City or Town, State, Zip Code) <b>868 Boatswain Way Annapolis, MD. 21401</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Resurrection Cemetery 8/14/91</b>		20c. LOCATION — City or Town, State <b>Clinton, MD.</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>Robert E. Wilhelm, Inc. 4308 Suitland Rd. Suitland, MD. 20746</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiopulmonary arrest</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Aspiration pneumonia</b> <b>Hypothyroidism</b>				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD		29c. LICENSE NUMBER <b>D08520</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Tomas J. Hernandez MD</b>				
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23698

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Shirley Howerton</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4am</b> M	
4. SOCIAL SECURITY NUMBER <b>525-13-3288</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9/17/12</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Oklahoma</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Univ Nsg Home 901 Arkla Ave</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Wheaton</b>		9c. COUNTY OF DEATH <b>Mont.</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Hyattsville</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5029 Edmonston Road</b>				10f. ZIP CODE <b>20781</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>YES- WW-2</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>NO</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>2 yrs.</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home Improvement company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>James Howerton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Roxie Mae Harris</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy A. Howerton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5029 Edmonston Road, Hyattsville, Maryland 20781</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland State Veteran Cemetery</b>		20c. LOCATION — City or Town, State <b>Cheltenham, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis Gasch</i>		22. NAME AND ADDRESS OF FACILITY <b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 BALT. AVE., HYATTSVILLE, MD. 20781</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. metastatic carcinoma</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Lenth</i>				29c. LICENSE NUMBER <b>D06684</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>AUG 11 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

(8) (IVA)



91 23699

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Michael Larry Harshman</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Aug. 21 1991</i>		3. TIME OF DEATH <i>4:10 P M</i>	
4. SOCIAL SECURITY NUMBER <i>220-42-6117</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>48</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>Oct. 5, 1942</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Washington Co. Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Hagerstown</i>		9c. COUNTY OF DEATH <i>Washington</i>	
RESIDENCE OF DECEDENT							
10a. STATE <i>MD</i>		10b. COUNTY <i>Washington</i>		10c. CITY, TOWN OR LOCATION <i>Smithsburg</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>Rt. 2 Box 419A</i>				10f. ZIP CODE <i>21783</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Sales Manager</i>		16b. KIND OF BUSINESS/INDUSTRY <i>News Distributor</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Roger Harshman</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Madge Henson</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Sharon Kay Harshman</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Rt. 2 Box 419A Smithsburg, MD 21783</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Smithsburg Crematory 8-22-91</i>		20c. LOCATION — City or Town, State <i>Smithsburg, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Hennis Davis</i>		22. NAME AND ADDRESS OF FACILITY <i>Davis Funeral Home Rt. 3 Box 78 Smithsburg, MD 21783</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>RESPIRATORY ARREST</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>ENCEPHALOPATHY</i> <i>HEPATIC INSUFFICIENCY</i> <i>METASTATIC COLON CARCINOMA</i>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>SEVERE MALNUTRITION</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Arveh L. Herrera M.D.</i>				29c. LICENSE NUMBER <i>D38466</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/23/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>ARVEH L. HERRERA M.D. 324 E ANTIETAM ST. HAGERSTOWN, 21740</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 27 '91</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 14



91 23700

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNA MARIE HUDSON</b>						2. DATE OF DEATH MONTH DAY YEAR <b>08 14 91</b>		3. TIME OF DEATH <b>0825</b> M			
4. SOCIAL SECURITY NUMBER <b>216-18-2147</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-12-23</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>406 EAST PINE STREET</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>DELMAR</b>			9c. COUNTY OF DEATH <b>WICOMICO</b>		
10a. STATE <b>Md.</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Delmar</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>406 E. Pine St.</b>						10f. ZIP CODE <b>21875</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Garment Co.</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Harvey Harrison McMahan</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Elizabeth (Maiden unknown)</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Curtis LeCompte</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>406 E. Pine St. Delmar, Md. 21875</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem. 8-16</b>		20c. LOCATION — City or Town, State <b>Hurlock, Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Short</i>				22. NAME AND ADDRESS OF FACILITY <b>Short Funeral Home, Inc. P.O. Box 204 Delmar, De. 19940</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. Bulkeley</i> <b>DEPUTY M.E.</b>						29c. LICENSE NUMBER <b>D03599</b>		29d. DATE SIGNED (Month, Day, Year) <b>08-14-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN T. BULKELEY, M.D. 108 PINE BLUFF ROAD SALISBURY MD 21801</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 16 91</b>				32. REGISTRAR'S SIGNATURE <i>John T. Bulkeley</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 63500

10/10/1960

10/10/1960

91-4583-045

91 23701

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Michael Thomas Hearne</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 09 1991</b>		3. TIME OF DEATH <b>3:10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-60-7739</b>		5. SEX <b>X M 2 F</b>		6. AGE (In yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-1-1954</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>South Division Street Bridge, in Wicomico River</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Mardela</b>		10d. INSIDE CITY LIMITS? <b>1 YES 2 X NO</b>	
10e. STREET AND NUMBER <b>Rt. 2 Box 669</b>				10f. ZIP CODE <b>21837</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 X YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>Vietnam</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Private</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Marine Corp</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Franklin T. Hearne</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Estella Watson Hearne</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Estella Hearne</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt#2 Box 669 Mardela, Md. 21837</b>			
20a. MANNER OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Springhill Memory Gardens 8-13</b>		20c. LOCATION — City or Town, State <b>Hebron, Md.</b>		20d. DATE <b>8-13</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Shortz</i>				22. NAME AND ADDRESS OF FACILITY <b>Short Windsor Disharoon Funeral Home, Inc. P.O. Box 678 Laurel, De. 19956</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Drowning</b> <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Schizophrenia</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Schizophrenia</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1 X YES 2 NO</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 X YES 2 NO</b>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 X YES 2 NO</b>
26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA</b> <b>OTHER: 4 Nursing Home 5 Residence 6 X Other (Specify) in water</b>		27. MANNER OF DEATH <b>1 Natural 2 Accident 3 X Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>					
28a. DATE OF INJURY (Month, Day, Year) <b>08 09 1991</b>		28b. TIME OF INJURY <b>2:20 P M</b>		28c. INJURY AT WORK? <b>1 YES 2 X NO</b>		28d. DESCRIBE HOW INJURY OCCURRED <b>Subject jumped from bridge on street</b>	
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. M. Dixon</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 10 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. M. Dixon 111 Penn Street. Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 '91</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10559 12

DHMH-18 Rev 1/89

25713 12

ITEMS: 23pt1, pt2, 27 per ME  
G-679 9/6/91 cm

91 23703

91-4521-037

1 -  
FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DAMIEN OBRIEN HOLLAND</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 06 1991</b>		3. TIME OF DEATH <b>09:43A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-21-9474</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>2</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG. 12, 1988</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>PATUXENT NAVAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>PATUXENT RIVER</b>	
9c. COUNTY OF DEATH <b>ST. MARYS</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S</b>	
10c. CITY, TOWN OR LOCATION <b>LEXINGTON PARK</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>62 SALAMAUA COURT</b>	
10f. ZIP CODE <b>20653</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>0</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>N/A</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>	
17. FATHER'S NAME (First, Middle, Last) <b>MICHAEL TORNEY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GAIL RENEE HOLLAND</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GAIL R. HOLLAND</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>62 SALAMAUA CT., LEXINGTON PARK, MD. 20653</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. EDMONDS METHODIST CEM 8/10/91</b>		20c. LOCATION — City or Town, State <b>CHESAPEAKE BEACH, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael R. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. INTERSTITIAL PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>STREPTOCOCCAL BACTEREMIA</b>							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Luke MD</i>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 07 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Luke MD 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 '91</b>				32. REGISTRAR'S SIGNATURE <i>Gina Davidson-Hendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JWR

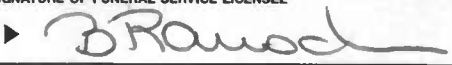
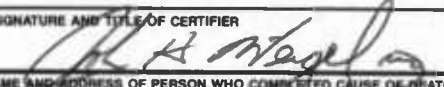
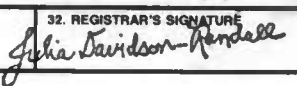




91 23704

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Margaret L. Hile</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 15, 1991</b>		3. TIME OF DEATH <b>10 A M</b>	
4. SOCIAL SECURITY NUMBER <b>578 24 0732 A</b>		5. SEX <b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12 16 06</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3450 Howard Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Port Republic</b>	
9c. COUNTY OF DEATH <b>Calvert</b>							
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince Georges</b>		10c. CITY, TOWN OR LOCATION <b>Capital Heights</b>		10d. INSIDE CITY LIMITS? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>	
10e. STREET AND NUMBER <b>907 Highview Drive</b>				10f. ZIP CODE <b>20673</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b> <b>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>sales Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Deptment Store</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robert S. Lowe</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Emelia Kallem</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Douglas R. Hile</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3450 Howard Drive Port Republic Maryland 20676</b>			
20a. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b> <b>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Grandview Cemetery 8 18 91</b>		20c. LOCATION — City or Town, State <b>Saxton, Bedford Pennsylvania</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Rausch Funeral Home</b> <b>4405 Broomes Is. Rd. Port Republic Maryland</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
a. <b>CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> OTHER: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>					
27. MANNER OF DEATH <b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b> <b>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide</b> <b>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined</b> <b>4 <input type="checkbox"/> Homicide</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>206358</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/16/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN H. WEISER MD - PRINCE FREDERICK MD - 20614</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 16 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1950-51



91 23705

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TIMOTHY SCOTT JONES, JR.				2. DATE OF DEATH MONTH 7 DAY 25 YEAR 1991		3. TIME OF DEATH 10:22 A.M.	
4. SOCIAL SECURITY NUMBER 234-29-8040		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 5 YRS.	7. DATE OF BIRTH (Month, Day, Year) May 9, 1986		8. BIRTHPLACE (State or Foreign Country) WEST VIRGINIA	
9a. FACILITY NAME (If not institution, give street and number) NAS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH PATUXENT RIVER		9c. COUNTY OF DEATH ST. MARY'S	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ST. MARY'S		10c. CITY, TOWN OR LOCATION ST. MARY'S CITY		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. BOX 42				10f. ZIP CODE 20686		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 8+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) _____		16b. KIND OF BUSINESS/INDUSTRY _____	
17. FATHER'S NAME (First, Middle, Last) TIMOTHY SCOTT JONES, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) CAROL LYNN JENKS			
19a. INFORMANT'S NAME (Type/Print) CAROL LYNN JENKS JONES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 42, ST. MARY'S CITY, MARYLAND 20686			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE _____		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Boyd</i>				22. NAME AND ADDRESS OF FACILITY BRINSFIELD FUNERAL HOME, P.A. LEONARDTOWN, MARYLAND 20650-0279			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. _____ DUE TO (OR AS A CONSEQUENCE OF):							
c. _____ DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 8 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William D. Boyd</i>				29c. LICENSE NUMBER D-14285		29d. DATE SIGNED (Month, Day, Year) July 25, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM D. BOYD, II, M.D., 17 JEFFERSON STREET, LEONARDTOWN, MARYLAND 20650							
31. DATE FILED (Month, Day, Year) AUG 22 '91				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 11

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

91 23706

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN JACOBS JOHN WESLEY JACOBS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 25 91</b>  |  | 3. TIME OF DEATH<br><b>7:45 A/M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-26-9573</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 21, 1929</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>CLINTON</b>  |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>   |  |
| 9b. FACILITY NAME (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>ST. MARY'S</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>MECHANICSVILLE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>4360 HARPER'S CORNER ROAD</b>   |  |
| 10f. ZIP CODE<br><b>20659</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6TH GRADE</b><br>College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>JANITOR</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RESTAURANT</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BERNARD A. JACOBS</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JUANITA HEBRON</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JACQUELINE E. YORKSHIRE</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4360 HARPER'S CORNER RD., MECHANICSVILLE, MD. 20659</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHARLES MEMORIAL GARNES 8/29/91 LEONARDTOWN, MD.</b>   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael K. Gardiner</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MATTINGLEY-GARDINER FUNERAL HOME, P.A.<br/>P.O. BOX 270, LEONARDTOWN, MARYLAND 20650</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SQUAMOUS CELL CARCINOMA of</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Oral cavity</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Keith H. Matten MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>028352</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-25-91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Suite 213 Pembroke Sq. Med. Center. Waldorf Md.</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 27 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Naomi L. JACKSON</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>8</i> - DAY <i>10</i> - YEAR <i>1991</i>  |  |   |  | 3. TIME OF DEATH<br><i>4:20 P.M.</i>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>217-32-0102</i>  |  |  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>79</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>May 25, 1921</i>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Wilson Health Care Center</i>   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Gaithersburg</i>                                  |  |  | 9c. COUNTY OF DEATH<br><i>MONTGOMERY</i> |   |  |
| 10a. STATE<br><i>Maryland</i>  |  |  |  | 10b. COUNTY<br><i>Montgomery</i>   |  |   |  | 10c. CITY, TOWN OR LOCATION<br><i>Silver Spring</i>  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><i>15801 Good Hope Road</i>  |  |   |  | 10f. ZIP CODE<br><i>20905</i>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                 |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>12th</i>  |  |   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Housewife</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Peyton E. Campbell</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary White</i>   |  |   |  | 19. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Naomi Johnson (Daughter)</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1884 Columbia Rd., NW #617, Wash. DC 20009</i>   |  |   |  | 20. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  |
| 20a. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Ash Memorial Cemetery 8/15</i>   |  |  |  | 20b. LOCATION — City or Town, State<br><i>Sandy Spring, MD</i>   |  |   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George R. Snowden</i>  |  |   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><i>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</i>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular accident</i><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><i>M</i>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>George R. Snowden</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>208546</i>   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>8-14-91</i>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>John P. Snowden 8218 Wisconsin Ave Bethesda</i>                                      |  |  |  | 31. DATE FILED (Month, Day, Year)<br><i>AUG 15 '91</i>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rodell</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LAURA B. JONES</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>2239</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-22-4382</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>01 20 99</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Bethesda</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6809 Greyswood Road</b>   |  |   |  | 10f. ZIP CODE<br><b>20817</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William L. Welch</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Ray</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Thelma L. Ball</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6809 Greyswood Road, Bethesda, MD 20817</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>8/14 Brentwood, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael E. Nelson</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph Gawler's Sons, Inc.</b><br><b>5130 Wisconsin Ave, NW, Washington, DC 20016</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Asystole</b>  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Atherosclerotic cardiovascular disease</b>  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Permanent pacemaker for cardiac conduction disease</b><br><b>Depression</b><br><b>Obstructive</b>   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residencia <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Byrl D. Johnson M.D.</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>0-19042</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/13/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BYRL D. JOHNSON M.D. 911 Russell Avenue Gaithersburg, Md. 20879</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



91 23709

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Inez Augusta Jones</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>19</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>1:56PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-28-4077</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>58</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>NOV 8, 1932</b>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital at Easton</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Easton, Maryland</b>  |  | 9c. COUNTY OF DEATH<br><b>Talbot</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Dorchester</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Cambridge</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>841 Park Lane</b>   |  |  |  | 10f. ZIP CODE<br><b>21613</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Johnson</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Flossie Roberts</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Velma Ross</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>841 Park Lane Camb, Md. 21613</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>St. Plasant Ceme</b>   |  | 20c. LOCATION — City or Town, State<br><b>Salem Md.</b>   |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Janelle C. Hay</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hennry F.H. Camb, Md. 21613</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | b. <b>ASVD</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
|  |  | c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
|  |  | d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ESRD on dialysis</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>005874</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/19/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>506 Solowild Avenue Easton, Maryland 21601</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 21 91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gina Davidson-Rendell</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Case 12

1. 1000 1000 1000

2. 1000 1000 1000

3. 1000 1000 1000

4. 1000 1000 1000

91 23710

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |   |
|---|--|--|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Millicent P. JACKSON  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 12, 1991   |  | 3. TIME OF DEATH<br>12:00 P M   |   |
| 4. SOCIAL SECURITY NUMBER<br>218-70-4043  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (in yrs. last birthday)<br>81 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>April 7, 1910  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Charlestown, MD   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Calvert Manor Nursing Home, Inc.  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rising Sun, MD   |  | 9c. COUNTY OF DEATH<br>Cecil  |   |
| RESIDENCE OF DECEDENT   |  |  |   |   |  |   |   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Cecil   |   | 10c. CITY, TOWN OR LOCATION<br>Charlestown  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>206 Caroline Street   |  |  |   | 10f. ZIP CODE<br>21914  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) n/a   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Home  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry McKown   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Kate Reilly  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Bonnie Giraldi   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>201 Jackson Station Road, Perryville, MD 21903   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Principio Cemetery 16-91  |   | 20c. LOCATION — City or Town, State<br>Perryville, Maryland   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Crouch Funeral Home<br>127 South Main St. North East, MD 21901  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CVA</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div>           a. <i>Artherosclerotic disease - Vascular</i><br/>           b. <i>Diabetes mellitus</i><br/>           c. <i>CAD</i> </div> </div> |  |  |   |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|   |  |  |   |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide 8 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |   | 29c. LICENSE NUMBER<br>MDD26183   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8-14-91  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Madhu S. Sachdev M.D. 3 North Main Street North East, MD 21901   |  |  |   |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>AUG 14 '91   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11/15/54

91 23711

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edward T JOHNSON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 15, 1991</b>  |  | 3. TIME OF DEATH<br>M<br><b>0930</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-34-7479</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 21, 1935</b>                                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Prince Frederick</b>  |  | 9c. COUNTY OF DEATH<br><b>Calvert</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Calvert</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Port Republic</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>5250 Broomes Island Road</b>   |  |  |  | 10f. ZIP CODE<br><b>20676</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>0-11</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Labor</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Gourley Johnson</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carrie Golder</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Josephine V. Johnson</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5250 Broomes Island Rd., Port Republic, Md 20676</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Brooks Church Cemetery 8/19/91</b>                     |  | 20c. LOCATION — City or Town, State<br><b>St. Leonard, Md</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Spencer E. Sewell</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1451 Dares Beach Rd.<br/>Sewell Funeral Home Prince Frederick, Md</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Left Cerebrovascular accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>① Seizure Disorder</b><br><b>② Recent Aspirin Pneumonia</b><br><b>③ Chronic Atelectasis Right Lower Lobe</b><br><b>④ Coronary Artery Disease</b><br><b>⑤ Old Myocardial Infarct</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>6-8 months</b>                               |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA               |  | OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>ATMunshi M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D19427</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/15/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Anwar Munshi, M.D. Prince Frederick, Maryland 20678</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Johia Davidson-Rendall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 2125-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23712

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THOMAS P. KENEFICK, JR.</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> - DAY <b>11</b> - YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>6:50 P. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-42-3835</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F              |  | 6. AGE (In yrs. last birthday)<br><b>47</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>NOV. 14, 1943</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WASHINGTON, D.C.</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>POTOMAC VALLEY NURSING HOME</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |   |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>407 WILLIAMSBURG DRIVE</b>  |  |
| 10f. ZIP CODE<br><b>20901</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE - American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>PRIEST</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RELIGIOUS</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>THOMAS P. KENEFICK, SR.</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FLORENCE BIGELOW</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>FLORENCE KENEFICK (MOTHER)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>407 WILLIAMSBURG DRIVE SILVER SPRING, MARYLAND 20901</b>                                  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>  |  | 20c. LOCATION - City or Town, State<br><b>SILVER SPRING, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James S. Dodey</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Probable cardiac arrhythmia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Electrolyte alterations</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Chronic renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension. Cardiomyopathy<br/>Diabetes. Peptic ulcer disease<br/>Hepatitis B. Asthma</b>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY - All home, farm, street, factory, office building, etc. (Specify) |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>H. Robert Birchbach MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>004115</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/11/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>H. Robert Birchbach MD<br/>4320 Democracy Blvd<br/>Bethesda MD 20814</i>  |  |   |  | 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>  |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23713

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY ANN KEATING</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> / DAY <b>10</b> / YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>4:24 A M</b>                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-48-8594</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>80 YRS.</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12/2/1910</b>              |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>                    |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>PRINCE GEORGE</b>                                     |  |
| 10c. CITY, TOWN OR LOCATION<br><b>HYATTSVILLE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>2011 Ravenswood Street</b>                 |  |
| 10f. ZIP CODE<br><b>20782</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>6 years</b>   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerk</b>   |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>   |  |   |  |
| 18. FATHER'S NAME (First, Middle, Last)<br><b>William Barkes</b>   |  |  |  | 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Ann Durr</b>   |  |   |  |
| 20a. INFORMANT'S NAME (Type/Print)<br><b>Terrence O. Keating</b>   |  |  |  | 20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>908 Davis Avenue Takoma Park, Md. 20912</b>   |  |   |  |
| 21. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 22. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Washington National Cemetery 8/14/91 Suitland, Maryland</b>   |  | 23. NAME AND ADDRESS OF FACILITY<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Md. 20705</b>  |  | 24. DATE<br><b>8/14/91</b>  |  |
| 25. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald V. Borgwardt</i>  |  | 26. NAME AND ADDRESS OF FACILITY<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Md. 20705</b>   |  | 27. DATE<br><b>8/14/91</b>  |  | 28. LOCATION — City or Town, State                                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOPULMONARY ARREST</b>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| b. <b>LIVER CANCER</b>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c. <b>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d.   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Paul M. G. [Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D25488</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/10/91</b>                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>6701 North Charles Street Towson, Maryland 21204</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson [Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RICHARD PAUL KUHN, JR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>AUGUST</b> DAY <b>14</b> , YEAR <b>1991</b>  |  | 3. TIME OF DEATH<br><b>11:15 A. M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-50-2545</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>43</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Jan. 17, 1948</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |  |  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>503 MARSHALL AVE.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>ROCKVILLE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>503 MARSHALL AVE.</b>   |  |  |  | 10f. ZIP CODE<br><b>20851</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Curator</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Art Gallery</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Paul Kuhn, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Betty Ann Miller</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Richard Paul Kuhn, Sr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as # 10</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Suburban Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, Maryland</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> <b>M00907</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>RAPP FUNERAL SERVICES, P.A.<br/>933 GIST AVE., SILVER SPRING, MD 20910</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>s. Adult Immunodeficiency Syndrome 3 years</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Hepatitis<br/>malnutrition</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>031839</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/14/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHRISTOPHER DUNFORD, M.D., 615 W. MONTGOMERY AVE., ROCKVILLE, MD 20850</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |  |   |   |
|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Maurice H. Krasow</b>   |   | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>12</b> YEAR <b>1991</b>   |   | 3. TIME OF DEATH<br><b>12:30AM</b>  |
| 4. SOCIAL SECURITY NUMBER<br><b>045-16-8935</b>  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/2/1907</b> |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Connecticut</b>   |   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery General Hospital</b>   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney</b>  |   | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |
| RESIDENCE OF DECEDENT  |   |  |   |   |
| 10a. STATE<br><b>Maryland</b>  | 10b. COUNTY<br><b>Montgomery</b>  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>  |   | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 10e. STREET AND NUMBER<br><b>15100 Interlachen Drive, #101</b>   |   | 10f. ZIP CODE<br><b>20906</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |   | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |   |  |   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>4</b>  |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Business Owner</b>  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Cameras/Photography</b>  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel Krasow</b>  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ancie Zabara</b>   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sylvia Krasow (wife)</b>  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15100 Interlachen Dr., #101 Silver Spring, MD 20906</b>  |   |   |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |   | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Lebanon Cemetery 8/13</b>  |   | 20c. LOCATION — City or Town, State<br><b>Adelphi, Maryland</b>   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |   | 22. NAME AND ADDRESS OF FACILITY<br><b>Danzansky-Goldberg Memorial Chapels, Inc.<br/>1170 Rockville Pike, Rockville, MD 20852</b>  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pulmonary Edema</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b><br>a. <b>Pulmonary Edema</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Ischemic Cardiomyopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Acute renal failure, Chronic Renal Failure.</b>   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |
|  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |   |   |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide<br><b>5</b> <input type="checkbox"/> Pending Investigation <b>6</b> <input type="checkbox"/> Could not be determined   |   | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY<br><b>M</b>                         | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |
|  |   | 28d. DESCRIBE NOW INJURY OCCURRED  |   | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Yackee MD</i>   |   | 29c. LICENSE NUMBER<br><b>D15362</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/12/91</b>   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Yackee MD 10401 Old Georgetown Rd Bethesda MD</b>   |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>   |   | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dr. Norman N. K. Katz   |  |  |  | 2. DATE OF DEATH<br>MONTH 8 DAY 11 YEAR 1991  |  | 3. TIME OF DEATH<br>13:30 P.M.   |   |
| 4. SOCIAL SECURITY NUMBER<br>274-50-4206  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>50 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>06-26-1941  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>INDIA   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>3020 Brown Stone Court   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BURTONSVILLE   |  | 9c. COUNTY OF DEATH<br>Montgomery Co.  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |   |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>MONTGOMERY  |  | 10c. CITY, TOWN OR LOCATION<br>BURTONSVILLE   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO             |   |
| 10e. STREET AND NUMBER<br>3020 BROWN STONE COURT  |  |  |  | 10f. ZIP CODE<br>20866  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>1963-1989  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>ASIAN                                  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>5+   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>PEDIATRIC OPHTHAMOLOGIST   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>UNKNOWN  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>UNKNOWN  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARGOT NELSON (SISTER-IN-LAW)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>24981 NEWBERRY DRIVE NOVI, MICHIGAN 48375  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>METROPOLITAN CREMATORY 8/15   |  | 20c. LOCATION — City or Town, State<br>ALEXANDRIA, VIRGINIA   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>FRANCIS J. COLLINS FUNERAL HOME, INC.<br>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. GUNSHOT WOUNDS HEAD AND NECK, AND ABDOMEN<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br><br><br>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                   |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>FOUND 8-11-91  |  | 28b. TIME OF INJURY<br>UNK M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |   |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED<br>SUBJECT SHOT  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>HOME  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>3020 BROWN STONE CT. |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Donald G. Wright MD  |  |  |  | 29c. LICENSE NUMBER<br>O. C. M. E.  |  | 29d. DATE SIGNED (Month, Day, Year)<br>08-12-1991  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DONALD G. WRIGHT, MD, DCME 111 PENN STREET BALTIMORE, MARYLAND 21201   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>AUG 16 '91   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |   |   |   |  |
|---|--|---|---|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John Martin Keeley  |  |   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 17, 1991   |  | 3. TIME OF DEATH<br>3:45 P M                            |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br>080-01-5959  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br>84 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN.   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 23, 1907 |   | 8. BIRTHPLACE (State or Foreign Country)<br>New York  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1316 Fenwick Lane, #406-407   |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Silver Spring  |  |   | 9c. COUNTY OF DEATH<br>Montgomery   |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Montgomery   |   | 10c. CITY, TOWN OR LOCATION<br>Silver Spring  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |   |  |
| 10e. STREET AND NUMBER<br>1316 Fenwick Lane   |  |   |   | 10f. ZIP CODE<br>20910  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States          |   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                       |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br>Unknown  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Computer Assembler   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>I. B. M.  |  |   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Martin Keeley  |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elizabeth Walker   |  |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Laurel M. Keeley  |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1615 Manchester Lane, NW, Washington, DC 20011   |  |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery   |   |   | 20c. LOCATION — City or Town, State<br>Silver Spring, Maryland                       |   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Eileen H. Rapp   |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br>Rapp Funeral Services, P. A.<br>933 Gist Avenue, Silver Spring, MD 20910  |  |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Prostate Cancer</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |   |   |  |   | Approximate Interval Between Onset and Death<br>3 yrs   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____   |  |   |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]  |   |   | 29c. LICENSE NUMBER<br>D 29294   |   | 29d. DATE SIGNED (Month, Day, Year)<br>August 19, 1991  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Everard H. Hughes, M. D., 10810 Connecticut Avenue, Kensington, MD 20895   |  |   |   |   |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 19 '91   |  | 32. REGISTRAR'S SIGNATURE<br>[Signature]  |   |   |  |   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TYPE 10

91 23718

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mabel Irene KOONTZ   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 21, 1991   |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-30-7683   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Dec. 13, 1907                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>5012 Harpers Ferry Rd.   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Sharpsburg   |  | 9c. COUNTY OF DEATH<br>WASHINGTON  |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Washington   |  | 10c. CITY, TOWN OR LOCATION<br>Sharpsburg  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>216-W. Chapline St.  |  |  |  | 10f. ZIP CODE<br>21782  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Melvin Francis  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Katherine Rebecca Hansell  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Shirley V. Phillips  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5012 Harpers Ferry Rd. Sharpsburg, MD 21782  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. View Cemetery  |  | 20c. LOCATION — City or Town, State<br>Sharpsburg, MD 21782   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>OSBORNE FUNERAL HOME<br>P.O. Box #348 Williamsport, MD 21795  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Adenocarcinoma colon metastatic to liver and lungs</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br>3 1/2 yrs.   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>R.L. Kugler MD  |  |  |  | 29c. LICENSE NUMBER<br>D 26577  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/21/91                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>R.L. Kugler MD 100 Geeting Lane Keedysville, MD 21756   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG '93 '91   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked for item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CITEC 12

91 23719

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ETHEL LETTIE KEFAUVER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>22</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>9:10 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-20-4516</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-10-1901</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 8c. COUNTY OF DEATH<br><b>Washington</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Boonsboro</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>3 Della Lane</b>   |  |  |  | 10f. ZIP CODE<br><b>21713</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Ororced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>11 yrs.</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Seamstress</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dress Manufacturer</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Daniel</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lettie Eakle</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia L. Gettridge</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3 Della Lane Boonsboro, Maryland 21713</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Boonsboro Cemetery 8-24-1991</b>   |  | 20c. LOCATION — City or Town, State<br><b>Boonsboro, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Douglas A. Fiery</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>7606 Old National Pike<br/>Bast Funeral Home Boonsboro, Maryland</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>congestive heart failure</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R. Guedenet</b>  |  | 29c. LICENSE NUMBER<br><b>D32578</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>82291</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. R. Guedenet M.D. 100 Geeting Lane Keedysville, Maryland 21756</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 23 '91</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01488 10



91 23720

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Gertrude Amanda KLASSEN   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 25, 1991   |  | 3. TIME OF DEATH<br>6:00 P.M.  |   |
| 4. SOCIAL SECURITY NUMBER<br>353-14-6658  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>94 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Nov. 7, 1896                                  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>222 S. North Street   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Maugansville   |  | 9c. COUNTY OF DEATH<br>Washington  |   |
| 10a. STATE<br>Maryland  |  |   |  | 10b. COUNTY<br>Montgomery   |  | 10c. CITY, TOWN OR LOCATION<br>Gaithersburg  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>419 Christopher #34   |  |  |   |
| 10f. ZIP CODE<br>20879  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 2  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>sales person  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>retail   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Paul Rudolf  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Caroline Meyer   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Carol Garrison  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>419 Christopher #34, Gaithersburg, Md. 20879   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Hagerstown Crematory  |  | 20c. LOCATION — City or Town, State<br>Hagerstown, Maryland   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott M. Minnick</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary artery Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>chronic obstructive Pulmonary Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |   |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                           |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                 |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 9 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dr. F. Yazdani   |  |   |  | 29c. LICENSE NUMBER<br>D37046   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/26/91                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Farshad Yazdani 1060 Chestwood Dr. Hagerstown, Md 21740  |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>AUG 27 '91   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

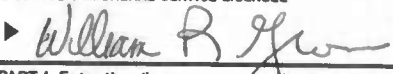

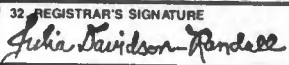
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alice Elizabeth King</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 17, 1991</b>  |  | 3. TIME OF DEATH<br><b>1059 A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>217-40-1899</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-16-1909</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Prince Frederick, Md.</b>   |  | 9c. COUNTY OF DEATH<br><b>Calvert</b>   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Lothian</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>5945 Fisher Station Road</b>   |  |  |  | 10f. ZIP CODE<br><b>20711</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>housewife</b>                 |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>-</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Benjamin Frank Ward</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marion Olivia Ireland</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William F. King</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5931 Fisher Station Rd., Lothian, MD 20711</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Friendship UM Ch. Cemetery 8/20/91 Friendship, MD</b>      |  | 20c. LOCATION — City or Town, State   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rausch Funeral Home, OWings, MD 20736</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Anoxic Brain damage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Ventricular tachycardia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Acute myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D23468</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/17/91</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Mark Kushner Prince Frederick, Maryland 20678</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 23 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br>                                 |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21115-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the certificate as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN E. LAZARUS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>3:40</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>197-07-9646 D</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 1, 1911</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Pleasant View Nursing Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Mount Airy</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>104 Charles Street</b>  |  |
| 10f. ZIP CODE<br><b>20850</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Marion Moxley</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nannie McGaha</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Gertrude A. Davis</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14029 Graceham Road, Thurmont, Maryland 21788</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Suitland, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Barbara Jo McMillen Lawrence</b> M00381   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/<br/>Rockville, Inc. 300 West Montgomery<br/>Avenue, Rockville, Maryland 20850-2805</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Lung Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Melvin J. Gordon MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D06588</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/13/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Melvin J. Gordon MD 4801 Dorsey Hall Drive Ellicott City MD 21042</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Aurilla Locust</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>8</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>1:35 4a.m.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>243-24-2626</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/30/28</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Dorchester Gen. Hospital</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cambridge</b>   |  | 8c. COUNTY OF DEATH<br><b>Dorchester</b>  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Dorchester</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Cambridge</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2441 Beltway</b>   |  |  |  | 10f. ZIP CODE<br><b>21613</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                                |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Roy Ennels</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Estella Ennels</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Fred Locust</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2441 Beltway Cambridge, Md. 21613</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Rock Lane</b>  |  | 20c. LOCATION — City or Town, State<br><b>Cambridge, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Janelle C. Henry</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Henry F. H. Cambridge, Md.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary hypertension</b><br>a. <b>Pulmonary Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval Between Onset and Death<br><b>Years</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Systemic Hypertension</b><br><b>Hypertrophic Cardiomyopathy</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   | 29c. LICENSE NUMBER  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Edmund MacLaughlin</b>  |  |  |  |   |  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/10/91</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Edmund MacLaughlin, M.D. Dorchester General Hospital Cambridge, MD 21613</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 21 91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Janelle C. Henry</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be detached for use as the burial-transit permit. Page 7, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

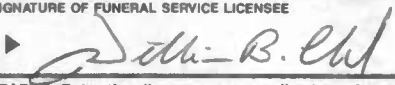

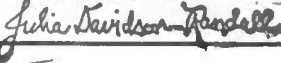
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23725

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Adela Lopez</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 15 91</b>  |  | 3. TIME OF DEATH<br><b>1:55 p M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-16-9923</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5 29 03</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sacred Heart Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hyattsville</b>  |  | 9c. COUNTY OF DEATH<br><b>Pr. Geo's.</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Pr. Geo's.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Hyattsville</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>5805 Queens Chapel Road</b>   |  |  |  | 10f. ZIP CODE<br><b>20783</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <b>Spanish</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Patrocinio Gallego</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Concepcion Naranjo</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Maria Luisa Araiza</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2480 - 16th Street, NW #530, Washington, DC 20009</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Suburban Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rapp Funeral Services, P.A.<br/>933 Gist Ave. Silver Spring, MD 20910</b>                                 |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>UPPER LIPS</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br><br>b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br><br>c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br><br>d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |  |  |   | Approximate interval Between Onset and Death<br><b>36 hours</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Senile dementia</b>   |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>022780</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/13/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Peter M Schissler MD 7500 Greenleaf Ctr Dr. Greenbelt Md 20770</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 19 '91</b>   |  | 32. REGISTRAR'S SIGNATURE<br>                                 |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23726

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Earl Christian Leather</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Aug. 21, 1991</b>   |  | 3. TIME OF DEATH<br><b>1:49 a. m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>A 705-10-7485</b>   |  | 5. SEX<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b> |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 21, 1902</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>2750 Virginia Avenue</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Williamsport</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |   |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Washington</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Williamsport</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>   |  | 10e. STREET AND NUMBER<br><b>2750 Virginia Avenue</b>  |  |
| 10f. ZIP CODE<br><b>21795</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b> |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b><br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12 years</b><br><b>College (1-4 or 5+) 2 years</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Former Supt. Transportation</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Western Maryland R. R.</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Christian Earl Leather</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Fannie M. Stoops</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nellie G. Leather</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2750 Virginia Avenue Williamsport, Maryland 21795</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald N. Minnich</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Gerald N. Minnich 305 N. Potomac Street<br/>Funeral Home Hagerstown, Maryland</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic prostatic carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ductal carcinoma<br/>Congestive heart failure</b>  |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b><br>OTHER: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |  |  |  |
| 27. MANNER OF DEATH<br><b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br/>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br/>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>  |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D268006</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/23/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>William S. H. MS 1610 Oak Hill Ave Hagerstown MD 21742</b>   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 23 '91</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1927 17

91 23727

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>ALVA LINDERMUTH</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 - 20 - 91</b>  |  | 3. TIME OF DEATH<br><b>10<sup>15</sup> A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>161-50-7200</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8 - 21 - 01</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FALLSTON GENERAL HOSP.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FALLSTON</b>  |  | 9c. COUNTY OF DEATH<br><b>HARFORD</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Harford</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Edgewood</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>606 Tupelo Court</b>  |  |  |  | 10f. ZIP CODE<br><b>21040</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Isaiah -- Rhoades</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ida Alice Beaver</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jean A. Kern</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>606 Tupelo Court, Edgewood, Md. 21040</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, etc.)<br><b>St. Paul Lutheran Church Cemetery</b>  |  | 20c. DATE<br><b>8-23-91</b>   |  | 20d. LOCATION — City or Town, State<br><b>Numidia, Pa.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Howard K. McComas III</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Howard K. McComas III Funeral Home, P.A.<br/>1317 Cokesbury Road, Abingdon, Md. 21009</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Liver and kidney failure</b>   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>30 days</b> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <b>Acute calculous cholecystitis</b>  |  |   |  |   | "  |
|  |  | c. <b>and choledocholithiasis</b>  |  |   |  |   | "  |
|  |  | d. <b>and cholelithiasis</b>   |  |   |  |   | "  |
|  |  | e. <b>and cholelithiasis</b>   |  |   |  |   | "  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus, Hypertension, Pancreatitis, Arteriosclerotic-cardiovascular disease</b>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>David M. Lanphear MD.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>DO 7071</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-20-91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David M. Lanphear MD Fallston MD</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 21 '01</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>L. B. Anderson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE E. LAUTERBACH</b><br>(Edwin)  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 15, 1991</b>  |  |  |  | 3. TIME OF DEATH<br><b>0112 am</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577 03 3465</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-5-1914</b>                               |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Wash. DC</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CALVERT MEMORIAL HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>PRINCE FREDERICK</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>CALVERT</b>   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Calvert</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Huntingtown</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>3026 Abington Manor Drive</b>  |  |  |  | 10f. ZIP CODE<br><b>20639</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>           |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinist</b>                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Business Machines</b>  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George E. Lauterbach</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alice Lucas</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary E. Lauterbach</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as 10 above</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Southern Mem. Gardens 8-19-91</b>  |  | DATE<br><b>8-19-91</b>  |  | 20c. LOCATION — City or Town, State<br><b>Dunkirk (Calvert) MD</b>                   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>M. Michael Phyllis</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rausch Funeral Home, Owings, MD 20736</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Atherosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Organic Brain Syndrome</b>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Lowenthal</i><br><b>J. LOWENTHAL, M.D.</b>   |  | 29c. LICENSE NUMBER<br><b>033123</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-15-91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. LOWENTHAL, M.D. PRINCE FREDERICK, MARYLAND 20678</b>   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lucile W. Magruder</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 13, 1991</b>   |  | 3. TIME OF DEATH<br><b>1:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-38-5960</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1905 August 17,</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>257 Congressional Lane #510</b>   |  | 10f. ZIP CODE<br><b>20852</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES          |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b> |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Tax Administration</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>City Government</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>George W. Weaver</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Maude Ricketts</b>  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Peggy Lou Newman</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>405 Carl Street, Rockville, Maryland 20851</b>         |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Mary's Catholic Cemetery 8/16/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Rockville, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael E. Higgins</i> M00846   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805</b>                                  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Restless lung disease</b><br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>2 wks</b><br><b>yes</b> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Med congestive Heart failure</b><br><b>Arthritis — malnutrition</b>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John S. SAI A MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>10493</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/13/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John S. SAI A MD 809 Viers Mill Rd, Rockville MD 20850</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 '91</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Pendell</i>   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Released by ME: Dr Mayle



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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THOMAS RICHLEY MATTINGLY</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUG. 21, 1991</b>  |  | 3. TIME OF DEATH<br><b>11:30 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-94-9339</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>26</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JAN. 30, 1965</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>MORGANZA</b>  |  | 9c. COUNTY OF DEATH<br><b>ST. MARY'S CO.</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |   |  |   |  |  |  |
| 10b. COUNTY<br><b>ST. MARY'S COUNTY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>MORGANZA</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>DR. JOHNSON ROAD</b>   |  |   |  | 10f. ZIP CODE<br><b>20660</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>9TH. GRADE</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>TRUCK DRIVER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CONSTRUCTION</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SCHERCLIFFE BARTHOLOMEW MATTINGLY</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AGNES CECILIA COPSEY</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>AGNES CECILIA MATTINGLY</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>DR. JOHNSON RD., MORGANZA, MD. 20660</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. JOSEPH'S CATHOLIC 8/26/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>MORGANZA, MARYLAND</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael L. Gardiner</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MATTINGLY-GARDINER FUNERAL HOME, P.A.<br/>P.O. BOX 270, LEONARDTOWN, MD. 20650</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Self inflicted Gun shot Wound to head instant</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident<br>3 <input checked="" type="checkbox"/> Suicide 9 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8/21/91</b>  |  | 28b. TIME OF INJURY<br><b>11:30 PM</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Self inflicted Gun shot</b>   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Dr Johnson Rd Morganza Md</b>  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF IDENTIFIER<br><i>[Signature]</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D19917</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/22/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JAMES C. BOYD, M.D. LEONARDTOWN, MARYLAND 20650</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 23 '91</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1975 10

91 23731

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ernest Mabry</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Aug. 11, 1991</b>  |  | 3. TIME OF DEATH<br><b>9:15 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>229-05-7189</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-15-11</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Pleasant View Nursing Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Mt. Airy</b>  |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Mt. Airy</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4601 Highboro Court</b>   |  |  |  | 10f. ZIP CODE<br><b>21771</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>8 years</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Carpenter</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private industry</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Roscoe C. Mabry</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Selma Horton</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Willard M. Mabry, Sr.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as # 10</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald V. Borgwardt</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Md. 20705</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Respiratory arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Parkinsons Disease</b><br><b>Cerebral Degeneration</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arthritis. Dysphagia. urinary infection</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>minutes</b><br><br><b>YRS</b><br><br><b>YRS</b> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Willard M. Mabry</b>   |  | 29c. LICENSE NUMBER<br><b>DO6588</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/12/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>4801 Dorsey Hall Dr. Sillicott City MD 21042</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 '91</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, illegible handwritten text]*



91 23732

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELLEN S. MULLER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>2:00 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>222-09-4298</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-22-1919</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Delaware</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Greater Laurel Beltsville Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Prince Georges</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Prince Georges</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>College Park</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>9407 48th Place</b>   |  |
| 10f. ZIP CODE<br><b>20740</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12 years</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cafeteria Management</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>P.G. County Schools</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert Simpson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Leona Darragh</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William H. Muller, Jr.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as #10</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>George Washington Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Adelphi, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald V. Borgwardt</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Donald V. Borgwardt Funeral Home, P.A.</b><br><b>4400 Powder Mill Rd. Beltsville, Md. 20705</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC COLON CARCINOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>SEPSIS</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |
| 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mark Parkhurst</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>024093</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/13/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARK PARKHURST MD 7305 BALT. AVE COLLEGE PARK MD 20740</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Randell</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2010-10-10

91 23733

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY M. MULLONEY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 7, 1991</b>   |  | 3. TIME OF DEATH<br><b>1030p</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>012-2844-32</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-10-03</b>  |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>4922 LASALLE ROAD</b>  |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>Hyattsville</b>  |  | 10. COUNTY OF DEATH<br><b>Prince George</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hyattsville</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
| 10e. STREET AND NUMBER<br><b>4922 LASALLE ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>20782</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>W.C.</b>                                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12</b>  |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bookkeeper</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private Company</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Howley</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Morgan</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Joan Van Horn (Daughter)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>504 6th Street, SE, Washington, DC 20003</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory (8-8-91)</b>  |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, Virginia</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DeVol Funeral Home</b><br><b>2222 Wisconsin Ave, NW, Wash, DC 20007</b> |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DeVol Funeral Home</b><br><b>2222 Wisconsin Ave, NW, Wash, DC 20007</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | Approximate Interval Between Onset and Death<br><b>minutes</b>   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | years  |  |
|  |  | c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |
|  |  | d. _____<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinson's Disease</b>   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                           |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Deputy Medical Examiner</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D01852</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-8-91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PAUL A. DeVORE MD 4203 QUEENSWAY Rd Hyattsville MD 20781</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 '91</b>   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23734

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BETTY JEAN MOWBRAY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUG 13 1991</b>   |  | 3. TIME OF DEATH<br>HOURS MIN. AM/PM<br><b>9:25 A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>520-07-4082</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB 24 1918</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MASSACHUSETTS</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>NATIONAL NAVAL MEDICAL CENTER</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>   |   |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>ROCKVILLE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>11415 COMMONWEALTH DRIVE</b>  |   |
| 10f. ZIP CODE<br><b>20852</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br><b>1942 - 1962</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nurse</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>National Institute of Health</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRANK WILLARD FOX</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>RHEA MAE MUNNELL</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>NICHOLAS FOX</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9008 RAIN TREE LANE, CHARLOTTE, NC 28277</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>August 15, 1991</b><br><b>MONTGOMERY CREMATORIUM INC.</b>  |  | 20c. LOCATION — City or Town, State<br><b>BETHESDA, MARYLAND</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George T. Koppert</i> <b>MO0335</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT A. PUMPHREY FUNERAL HOME/</b><br><b>BETHESDA CHEVY CHASE, INC. 7557 WISCONSIN</b><br><b>AVENUE BETHESDA, MARYLAND 20814</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>b. <b>SEPTIC SHOCK</b><br>c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br>d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |  |  |  | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>HOURS MIN. AM/PM<br><b>M</b>  |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward J. Balbona M.D.</i>   |  |  |   |
| 29c. LICENSE NUMBER  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>14 Aug 91</b>  |  |  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>E. J. BALBONA, LT, MC, USN</b>   |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>AUG 19 '91</b>   |  |  |   |
| 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |  |  | 33. DATE OF DEATH (Month, Day, Year)<br><b>AUG 13 1991</b>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS:23,27 per ME

G-679 9/6/91 cm

91-4660-031

91 23735

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Patrick Bernard Mather</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 14 1991</b>  |  | 3. TIME OF DEATH<br>HOURS MIN. SEC.<br><b>2:31 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>328-72-5124</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>9</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Mar. 17, 1982</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Illinois</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>11801 Ashley Drive</b>  |  |
| 10f. ZIP CODE<br><b>20852</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>None</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>None</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William S. Mather, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Susan Bartose</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William S. Mather, Sr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11801 Ashley Drive, Rockville, Maryland 20852</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc. 8/17/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Bethesda, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Barbara J. McMullen Lawrence</b> M00381  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/<br/>Bethesda-Chevy Chase, Inc. 7551 Wisconsin<br/>Avenue, Bethesda, Maryland 20814-3501</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARRHYTHMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dennis J. Chute M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08 15 1991</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DENNIS J. CHUTE, M.D. 111 Penn Street, Baltimore Maryland 21201</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 19 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6-7-53 10

4-11-10-10-10

4-11-10-10-10


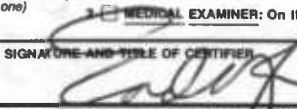
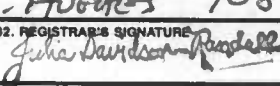
4-11-10-10-10



91 23736

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ARLINE S. MARGOLIS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>6:00 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>078-20-9504</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-10-28</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>9531 Fern Hollow Way</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Gaithersburg</b>  |  | 8c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Gaithersburg</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>9531 Fern Hollow Way</b>   |  |  |  | 10f. ZIP CODE<br><b>20879</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 8+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bookkeeper</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Furniture</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Morris J. Stone</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Etta Berkowitz</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Seymour Margolis</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9531 Fern Hollow Way, Gaithersburg, MD. 20879</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Lebanon Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Adelphi, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Danzansky-Goldberg Memorial Chapels, Inc.<br/>1170 Rockville Pike, Rockville, MD. 20852</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Breast Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Metastatic Breast Cancer</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death <b>3 years</b> |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28a. PLACE OF INJURY — All home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D29294</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/13/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>EVERARD H. HUGHES 10810 Connecticut Avenue Kensington MD</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 10



91 23737

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Rose Marcus</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>10</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>6<sup>00</sup> A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>119-20-4602</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/30/1898</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NEW YORK</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>SPRINGBROOK ADVENTIST NURSING CENTER</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>  |   |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>508 DERRYDOWN LANE</b>  |   |
| 10f. ZIP CODE<br><b>20904</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>11</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>DOMESTIC</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHARLES TIGER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FANNIE DIAMOND</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DR. CHARLES MARCUS (SON)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>508 DERRYDOWN LANE, SILVER SPRING, MD 20904</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>NEW MONTEFIORE CEMETERY 8/12</b>   |  | 20c. LOCATION — City or Town, State<br><b>PINELAWN, L.I., NY</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br/>1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>Lymphoma with Metastasis to Brain</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>S. Trifoglio MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D37934</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/10/91</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S. Trifoglio, MD 7500 Greenway Ctr Drive #430 Greenbelt MD 20770</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Gelia Davidson-Rodell</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05 23121

91 23738

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SADIE PATSY Mc COR MICK</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>12</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>1430</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>226-26-2337</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-24-26</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>   |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring -</b>  |  | 10. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 11. FACILITY NAME (If not Institution, give street and number)<br><b>Holycross Hospital</b>   |  |  |  | 12. RESIDENCE OF DECEDENT<br><b>MD</b>  |  | 13. COUNTY<br><b>MONTGOMERY</b>  |  |
| 14. STATE<br><b>MD</b>  |  |  |  | 15. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>  |  | 16. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 17. STREET AND NUMBER<br><b>2806 HENDERSON COURT</b>  |  |  |  | 18. ZIP CODE<br><b>20902</b>  |  | 19. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 20. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 21. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 23. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                     |  |
| 24. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECRETARY</b>  |  | 26. KIND OF BUSINESS/INDUSTRY<br><b>DOCTOR'S OFFICE</b>   |  |  |  |
| 27. FATHER'S NAME (First, Middle, Last)<br><b>DAVID PRESTON CARDER</b>  |  |  |  | 28. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FRENCHIE THOMAS</b>   |  |  |  |
| 29. INFORMANT'S NAME (Type/Print)<br><b>MICHAEL P. McCORMICK (SON)</b>  |  |  |  | 30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 316 SOLOMONS ISLAND, MARYLAND 20686</b>   |  |  |  |
| 31. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>PARKLAWN CEMETERY</b>   |  | 33. DATE<br><b>8/16</b>   |  | 34. LOCATION — City or Town, State<br><b>ROCKVILLE, MARYLAND</b>                               |  |
| 35. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 36. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL. SPR., MD 20688</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC LUNG CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |  |
| b. <b>SMOKING</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ATRIAL FIBRILLATIONS, POSSIBLE ATRIAL MYXOMA,<br/>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>  |  |  |  |   |  |  |  |
| 37. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 38. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 39. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 40. DATE OF INJURY (Month, Day, Year)  |  | 41. TIME OF INJURY<br><b>M</b>  |  | 42. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 43. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 44. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 45. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 46. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD  |  | 47. LICENSE NUMBER<br><b>D36252</b>   |  | 48. DATE SIGNED (Month, Day, Year)<br><b>8/12/91</b>   |  |
| 49. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>STEVEN T. KARIYA, MD, 4701 RANDOLPH ROAD #G3 ROCKVILLE MD 20852</b>   |  |  |  |   |  |  |  |
| 50. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>  |  | 51. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00507 00

91 23739

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Paulina Marshall</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>8</i> DAY <i>11</i> YEAR <i>91</i>   |  | 3. TIME OF DEATH<br><i>4:30 A M</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>577-58-7251</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>93</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>Feb. 7, 1898</i>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Lithuania</i>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Presidential Woods Health Care Ctr</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Adelphi</i>   |  | 9c. COUNTY OF DEATH<br><i>Prince Georges</i>  |  |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Prince Georges</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Lanham</i>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>9322 Wyatt Drive</i>   |  | 10f. ZIP CODE<br><i>20706</i>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>2</i> College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Registered Nurse</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Nursing</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Antanas Stacas</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Elzbieta Bertulyte</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Aldona Simanavichus</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>9322 Wyatt Dr., Lanham, Maryland 20706</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Mt. Olivet Cemetery 8-14-91</i>  |  | 20c. LOCATION — City or Town, State<br><i>Washington, D.C.</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard Decker</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Rendon-Hale Lanham Funeral Home<br/>9013 Annapolis Rd., Lanham, Maryland 20706</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary Arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Cerebrovascular accident</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Recurrent Aspiration</i>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>S. Trifoglio MD</i>  |  | 29c. LICENSE NUMBER<br><i>D37934</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>8/11/91</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>S. Trifoglio, MD 7500 Greenway Center Drive #430 Greenbelt MD 20770</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>AUG 14 '91</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23740

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Thomas L. Mattingly, Jr.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 12 1991  |  | 3. TIME OF DEATH<br>3:50 p.m.  |   |
| 4. SOCIAL SECURITY NUMBER<br>578-30-5438   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>66 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 3, 1925                              |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Washington, D.C.   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Veterans Administration Medical Ctr.  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Perry Point                               |   |
| 9c. COUNTY OF DEATH<br>Cecil   |  |  |  | 10a. STATE<br>Maryland  |  |  |   |
| 10b. COUNTY<br>Prince George's   |  | 10c. CITY, TOWN OR LOCATION<br>Camp Springs  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |   |
| 10e. STREET AND NUMBER<br>4911 Cleveland Court   |  |  |  | 10f. ZIP CODE<br>20748  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                 |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) College   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Clerk  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Federal Government<br>Veterans Administration   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas L. Mattingly, Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna Margaret Burkhard   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Paul V. Mattingly  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4911 Cleveland Ct. Camp Springs, Md. 20748   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery  |  | 20c. LOCATION — City or Town, State<br>Suitland, Maryland   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George P. Kalas</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br>George P. Kalas Funeral Home<br>6160 Oxon Hill Rd. Oxon Hill, Md. 20745  |  |   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lymphoma with metastasis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Emphysema  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stanley I. Phillips M.D.</i>   |  | 29c. LICENSE NUMBER<br>MD 25622   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8-13-91                                   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>STANLEY I. PHILLIPS, M.D., VA Medical Center, Perry Point, MD 21902   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>AUG 14 '91  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

PAGES 10

91 23741

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Sharon Milner Moss</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>8</i> DAY <i>8</i> YEAR <i>91</i>   |  | 3. TIME OF DEATH<br><i>4:20 A M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>439-96-3578</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>36</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>July 29, 1955</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Louisiana</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Shady Grove Adv. Hospital</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Gaithersburg, Md.</i>  |  |
| 9c. COUNTY OF DEATH<br><i>Montgomery</i>   |  |  |  | 10a. STATE<br><i>Md.</i>   |  | 10b. COUNTY<br><i>Montgomery</i>   |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Gaithersburg</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>19418 Kildonan Drive</i>  |  |
| 10f. ZIP CODE<br><i>20879</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>BLACK</i>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>4 yrs</i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Information Security Sp.</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Howard University</i>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Harvey Milner</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Ada Graham</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Jimmy Moss</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>19418 Kildonan Dr.; Gaithersburg, Md. 20879</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Kennon and Sons Funeral Home Minden, La.</i>  |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Julia P. Marshall</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Marshall's Funeral Home<br/>4217 9th St NW: Washington, D.C.</i>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CARDIOPULMONARY ARREST</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>METASTATIC SYNOVIAL CELL CARCINOMA</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>UNDERLYING CAUSE: METASTATIC SYNOVIAL CELL CARCINOMA</i><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><i>M</i>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James M. Trehan MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D-33224</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>8/9/91</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>R Trehan MD 50 W Edmonston Dr # 504, Rockville MD 20852</i>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>AUG 13 91</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23742

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |   |
|--|--|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN G. MASSERON</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>8</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>2:45 P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-58-2819</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 18, 1905</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Berlin Nursing Home, Inc.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Berlin</b>  |   |
| 9c. COUNTY OF DEATH<br><b>Worcester</b>  |  |   |  | RESIDENCE OF DECEDENT  |  |   |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Worcester</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Berlin</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>#6 Yeomans Ct.</b>  |  |   |  | 10f. ZIP CODE<br><b>21811</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>NO</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:<br><b>NO</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                          |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>-----</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Eugene A. Tracey</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary A. Garrick</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Eugene J. Masseron, Jr.</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5100 Park Lake Drive, Melbourne, Florida 32901</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>-----</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, Md.</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Mark M. Brohman</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A.<br/>4739 BALT. AVE., HYATTSVILLE, MD. 20781</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>ASCVD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Cancer of Colon</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Alzheimer's Disease</b> |  |   |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>  |  |   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>-----</b>  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>-----</b>   |  | 28b. TIME OF INJURY<br><b>M</b>   |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE NOW INJURY OCCURRED<br><b>-----</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>-----</b>   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>-----</b>        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Federico G. Arthes</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D02026</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-8-91</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Federico G. Arthes, M.D., 10622A Ocean Pines, Berlin, MD 21811</b>   |  |   |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 11 '91</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23743

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |  |   |  |
|--|--|--|--|---|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RAYMOND C. MC CAULEY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>22</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>1:25</b> M  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-28-7413</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (in yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 4, 1919</b>  |   |  |   |  |
| 8. BIRTHPLACE (State and Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>   |   |  |   |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>   |   |  |   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>909 Beechwood Drive</b>   |   |  |   |  |
| 10f. ZIP CODE<br><b>21740</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |  |   |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>8</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mechanic</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Automobile Dealership</b>   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Claggett</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bessie Edith Startzman</b>  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Jane Mc Cauley</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>909 Beechwood Drive, Hagerstown, Maryland 21740</b>   |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory 8-22-91 Smithsburg, Wash. Md.</b>  |  | 20c. LOCATION — City or Town, State  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. Neil Brady</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Andrew K. Coffman Funeral Home, Inc.<br/>40 East Antietam St., Hagerstown, Md. 21740</b>   |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>metastatic Brain Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cholesterol</b> |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY  |   |  |   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>C. C. Sullivan MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D18127</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/22/91</b>  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>C. C. Sullivan MD 370 Mill St. Hagerstown 21740</b>  |  |  |  |   |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 23 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ross Charles Moser   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 21, 1991  |  |   |  | 3. TIME OF DEATH<br>1 P M   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-14-7222   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>77 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>12/ 4/13  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown  |  |   |  | 9c. COUNTY OF DEATH<br>Washington   |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  | 10c. CITY, TOWN OR LOCATION  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO           |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |  | 10c. CITY, TOWN OR LOCATION<br>Myersville  |  |   |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>2416 Monument Road   |  |  |  | 10f. ZIP CODE<br>21773   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>truck driver  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Frederick County Road Dept.   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Henry Moser   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Katie Orene Koogle  |  |   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jennie Louise Moser  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2416 Monument Road Myersville, MD 21773   |  |   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Paul's Lutheran Cemetery   |  |   |  | 20c. LOCATION — City or Town, State<br>Myersville, MD   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Randy L. Richards   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ricketts Funeral Home 504 Main Street<br>Myersville, MD 21773  |  |   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intracerebral hematoma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br>days  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>July 30, 1991   |  | 28b. TIME OF INJURY<br>P M                |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO               |  | 28d. DESCRIBE HOW INJURY OCCURED<br>fell from bridge  |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>bridge   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Monument Road, Myersville, Md |  |   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  |  |  | 29c. LICENSE NUMBER<br>D11266             |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/23/91  |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>580 Northern Avenue, Hagerstown, Maryland 21742   |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 23 '91  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23745

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Lawrence Marsielles Murphy, Jr.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>8 25 91   |  | 3. TIME OF DEATH<br>2 49 p.m.  |  |
| 4. SOCIAL SECURITY NUMBER<br>579-34-8998  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>64 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Aug. 3, 1927   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Washington, D. C.   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown  |  |
| 9c. COUNTY OF DEATH<br>Washington   |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Washington  |  |
| 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>10 Catawba Circle  |  |
| 10f. ZIP CODE<br>21740  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 years<br>College (1-4 or 5+) 4 years   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>claims supervisor  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>insurance  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lawrence Marsielles Murphy, Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anne Bailey  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Barbara A. Murphy   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10 Catawba Circle Hagerstown, Maryland 21740   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Smithsburg Crematory   |  | 20c. LOCATION — City or Town, State<br>Smithsburg, Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Gerald N. Minnich  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Gerald N. Minnich 305 N. Potomac Street<br>Funeral Home Hagerstown, Maryland  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac arrest</u>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| b. <u>severe left ventricular dysfunction</u>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| c. <u>severe coronary artery disease</u>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| d. <u>ischemic bowel</u>  |  |  |  |   |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>severe peripheral vascular disease</u>   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28. DATE OF INJURY (Month, Day, Year)   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Stephen M. Sachs, MD   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/25/91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>STEPHEN M. SACHS 239 N. Potomac ST. HAGERSTOWN   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 27 '91   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DATE 11

91 23746

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Vivian Summers Miller  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>8 23 91  |  |   |  | 3. TIME OF DEATH<br>0110 M  |  |  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-10-5499   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>82 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Oct. 23, 1908             |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  |   |  | 9c. COUNTY OF DEATH<br>Washington                                |  |   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington  |  | 10c. CITY, TOWN OR LOCATION<br>Williamsport  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>2750 Virginia Avenue   |  |  |  |  |  | 10f. ZIP CODE<br>21795  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                             |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (14 or 5+)<br>12 years  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>home  |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Otho Lee Summers  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Bessie Doub  |  |   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Philip L. Miller   |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11025 Clinton Avenue Hagerstown, Maryland 21740  |  |   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Beaver Creek Brethren Church Cemetery 8/26  |  |   |  | 20c. LOCATION — City or Town, State<br>Beaver Creek Maryland  |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Gerald N. Minnich   |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Gerald N. Minnich Funeral Home 305 N. Potomac Street Hagerstown, Maryland   |  |   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RUPTURED ABDOMINAL AORTIC ANEURYSM<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br>2-3 HOURS   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HYPERTENSION   |  |  |  |  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED                                |  |   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Randall Fox Bradford, M.D.  |  |  |  |  |  | 29c. LICENSE NUMBER<br>D38892   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/23/91                   |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>AMERICA FOX BRADFORD MD 1799 HOWELL RD. HAGERSTOWN, MD 21740  |  |  |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 27 '91  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Pandora  |  |   |  |   |  |  |  |   |  |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



91 23747

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Arbie L. MOSER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 24, 1991</b>  |  | 3. TIME OF DEATH<br><b>11:43 A. M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-54-6600</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 11, 1897</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Clevelandville</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Cuppett- Weeks Nursing Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Oakland</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Md.</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Boonsboro</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>Rfd. 3</b>  |  |
| 10f. ZIP CODE<br><b>21713</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Unknown</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Never Employed</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lewis M. Moser</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Beachley</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Bast Funeral Home Records</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7606 Old National Pike, Boonsboro, Md. 21713</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Boonsboro Cemetery</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Boonsboro, Md.</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John H. Bast, Jr.</b>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>BAST FUNERAL HOME, Boonsboro, Md. 21713</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Atherosclerosis</b><br><br><b>Chronic renal failure</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>Aug 27 '91</b>   |  |  |  |
| 28b. TIME OF INJURY<br><b>—</b> M   |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Accident MD 21520</b>   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>—</b>  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>—</b>  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D25759</b>  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>08-24-91</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Walter E. Naumann, MD</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 27 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John H. Bast, Jr.</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23748

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dorothy P. MITCHELL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 23, 1991</b>   |  | 3. TIME OF DEATH<br>M<br><b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-18-7214</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 16, 1920</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Washington</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>2101 Youngstown Drive</b>   |  |
| 10f. ZIP CODE<br><b>21740</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>food demonstrator</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>market</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Atwell Picadat</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Winfree</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robyn D. Daley</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P. O. Box 1097, Hagerstown, Md. 21741</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Memorial Park 8/26</b>  |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott M. Minnich</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiogenic shock</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>acute myocardial infarct</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ischemic cardiomyopathy</b>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Say C Papachis MD</i>  |  | 29c. LICENSE NUMBER<br><b>D32851</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>8/23/91</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Say C Papachis MD 354 Mill St Hagerstown MD 21740</b>  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 26 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |                                |  |  |
|--|--|--|--|---|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SARA A. MILLER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUG 11 1991</b>  |                                | 3. TIME OF DEATH<br><b>14:03 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>208-22-3926</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAY 30 1928</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNION HOSPITAL</b>   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ELKTON</b>   |  |
| 9c. COUNTY OF DEATH<br><b>CECIL</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |                                |  |  |
| 10b. COUNTY<br><b>CECIL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>CONOWINGO</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |                                |  |  |
| 10e. STREET AND NUMBER<br><b>905 ROCKSPRINGS ROAD</b>  |  |  |  | 10f. ZIP CODE<br><b>21918</b>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>   |                                |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE MIMM</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ETHEL TROUPE</b>  |                                |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CLARK R. MILLER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>905 ROCKSPRINGS RD, CONOWINGO, MD 21918</b>   |                                |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WEST NOTTINGHAM</b>   |  | 20c. LOCATION — City or Town, State<br><b>COLORA, MARYLAND</b>  |                                |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard L. Goodie</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>R.T. FOARD FUNERAL HOME<br/>RISING SUN, MARYLAND</b>   |                                |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>anterior wall MI</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>ischemic cardiomyopathy</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>arteriosclerotic coronary artery disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |                                | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |                                | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |                                | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |                                |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kenneth S. Lewis</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>C1 0001534</b>  |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/14/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KENNETH S. LEWIS, MD 12 PENNINGTON STREET, MIDDLETOWN, DELAWARE</b>  |  |  |  |   |                                |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |                                |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEMS: 9a-9c per ME  
G-679 9/6/91 cm

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91-4650-510

FOR  
STATE  
1 - REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT B. MADRON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>14</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>7:13 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>224-13-1742</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>27</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 12, 1964</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL (SHOCK TRAUMA)<br/>THEODORE RD. &amp; Belvedere rd</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY<br/>Port Deposit</b>  |  |
| 9c. COUNTY OF DEATH<br><b>CECIL COUNTY</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Cecil</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Port Deposit</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>7 Honeysuckle Drive</b>   |  |
| 10f. ZIP CODE<br><b>21904</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 years</b> College (1-4 or 5+) <b>2 years</b>  |  |  |  |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Superintendent Water Plant</b>   |  |  |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>Town of North East, Md.</b>   |  |  |  |
| 18. FATHER'S NAME (First, Middle, Last)<br><b>Archie R. Madron Jr.</b>   |  |  |  | 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Donna L. Parker</b>   |  |  |  |
| 20. INFORMANT'S NAME (Type/Print)<br><b>Archie R. Madron</b>   |  |  |  | 21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 Honeysuckle Drive, Port Deposit, Md. 21904</b>   |  |  |  |
| 22. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                       |  |  |  | 23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>West Nottingham Cemetery 8/17</b>  |  |  |  |
| 24. LOCATION — City or Town, State<br><b>Colora, Maryland.</b>   |  |  |  | 25. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lee A. Patterson</i>  |  |  |  |
| 26. NAME AND ADDRESS OF FACILITY<br><b>Lee A. Patterson &amp; Son Funeral Home<br/>Perryville, Maryland. 21903</b>   |  |  |  | 27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |
| 28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 29. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| 30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 31. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |
| 32. HOSPITAL:<br><input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA   |  |  |  | 33. OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 34. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |  |  | 35. DATE OF INJURY (Month, Day, Year)<br><b>08/14/91</b>  |  |  |  |
| 36. TIME OF INJURY<br><b>5:00P M</b>   |  |  |  | 37. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>   |  |  |  | 39. DESCRIBE HOW INJURY OCCURRED<br><b>Motorcycle impact auto</b>   |  |  |  |
| 40. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Theodore &amp; Belvedere rds.</b>  |  |  |  | 41. CERTIFIER<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 42. SIGNATURE AND TITLE OF CERTIFIER<br><i>Thomas M. J. H.</i>   |  |  |  | 43. LICENSE NUMBER<br><b>O.C.M.E.</b>   |  |  |  |
| 44. DATE SIGNED (Month, Day, Year)<br><b>08/15/91</b>  |  |  |  | 45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARGARET A. WOREL 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>  |  |  |  |
| 46. DATE FILED (Month, Day, Year)<br><b>AUG 16 '91</b>   |  |  |  | 47. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ralph William Martinez   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>08 20 91   |  | 3. TIME OF DEATH<br>0522 M   |   |
| 4. SOCIAL SECURITY NUMBER<br>060-05-3791   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>77 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>09-27-1913  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Indiana  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Carroll County General Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Westminster   |   |
| 9c. COUNTY OF DEATH<br>Carroll   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Carroll   |   |
| 10c. CITY, TOWN OR LOCATION<br>Westminster   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>96 Timber Ridge  |   |
| 10f. ZIP CODE<br>21157   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (10-12) 12 College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Owner  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Drug Store   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Albert Martinez   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Manuela Abona   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Phyllis M. Martinez  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>96 Timber Ridge, Westminster, MD 21157  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Carroll Crematory  |  | 20c. LOCATION — City or Town, State<br>Hampstead, MD   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert A. Myers   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Myers Funeral Home<br>91 Willis Street, Westminster, MD  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIO PULMONARY ARREST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ANEMIA<br>GOUT<br>HYPERTENSION   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]   |  |  |  | 29c. LICENSE NUMBER<br>D29246  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8.20.91   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>N. RAJPARA, MD, 217 WASHINGTON RD. WESTM. 21157   |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>AUG 21 '91  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EVELYN VIRGINIA MACKALL   |  |  |  | 2. DATE OF DEATH<br>AUGUST 25, 1991   |  | 3. TIME OF DEATH<br>0100 M  |  |
| 4. SOCIAL SECURITY NUMBER<br>217-36-3223  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>53 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Dec. 02, 1937  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>CALVERT MEMORIAL HOSPITAL  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>PRINCE FREDERICK   |  | 9c. COUNTY OF DEATH<br>CALVERT  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Prince George   |  | 10c. CITY, TOWN OR LOCATION<br>Forestville  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>6519 Hilmar Drive Apt. 204  |  |  |  | 10f. ZIP CODE<br>20747  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0-9 College (1-4 or 6+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Domestic  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Benjamin Brown   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lelia Stepney  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Maxine E. Mackall   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Box 271 Mt. Harmony Road, Owings, Md 20736   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Coopers Church Cemetery 8/29/91                               |  | 20c. DATE<br>8/29/91  |  | 20d. LOCATION — City or Town, State<br>Dunkirk, Md  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Spencer E. Sewell  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>1451 Dares Beach Rd.<br>Sewell Funeral Home Prince Frederick, Md  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute myocardial infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Uncontrolled diabetes<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sun exposure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST         |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. DESCRIBE HOW INJURY OCCURRED   |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Emad Al Banna  |  |  |  | 29c. LICENSE NUMBER<br>D12705   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/25/91  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>EMAD AL BANNA, M.D., PRINCE FREDERICK, MD. 20678   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 27 1991  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use with the funeral permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first of these is the fact that the

the second of these is the fact that the

the third of these is the fact that the

the fourth of these is the fact that the

the fifth of these is the fact that the

the sixth of these is the fact that the

the seventh of these is the fact that the

the eighth of these is the fact that the

the ninth of these is the fact that the

the tenth of these is the fact that the

the eleventh of these is the fact that the

the twelfth of these is the fact that the

the thirteenth of these is the fact that the

the fourteenth of these is the fact that the

the fifteenth of these is the fact that the

the sixteenth of these is the fact that the

91 23753

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William V. Nole</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 12, 1991</b>   |  | 3. TIME OF DEATH<br><b>4:44 p. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>069-09-6395 A</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 1, 1911</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery General Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>14626 Bauer Drive #2</b>  |  |
| 10f. ZIP CODE<br><b>20853</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Metal Worker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Revere Copper &amp; Brass</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Nole</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Vaccaro</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Philomena B. Nole</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14626 Bauer Drive #2 Rockville, Maryland 20853</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery August 16, 1991</b>  |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George J. Kephart M00335</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b>   |  |  |  |  |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF): <b>EMPHYSEMA</b>   |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Frank J. Mayo, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 23630</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-12-91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Frank J. Mayo, M.D. 16220 Frederick Rd. #213, Gaithersburg, MD 20877</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

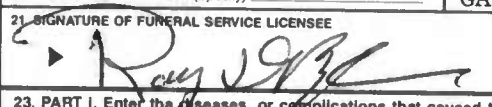
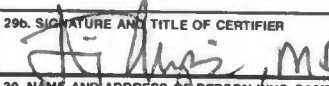
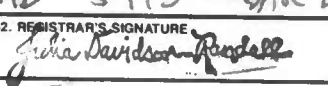
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01-03-19

91 23754

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>Philip Norris</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>15</b> YEAR <b>91</b>   |  |   |  | 3. TIME OF DEATH<br><b>6 12 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-09-6929</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>OCT. 26, 1902</b>                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>WASHINGTON, D.C.</b>                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BETHESDA</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7915 QUARRY RIDGE WAY</b>  |  |  |  | 10f. ZIP CODE<br><b>20817</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>12</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECRETARY</b>               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>KANE TRANSFER</b>   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN T. NORRIS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY EICHHORN</b>  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>PHYLLIS NORRIS DUREK (DAUGHTER)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7915 QUARRY RIDGE WAY BETHESDA, MARYLAND 20817</b>   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>                            |  | DATE<br><b>8/19</b>  |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>                       |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>MEDIASTINAL MASS</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br/>CORONARY ARTERY DISEASE, CONGESTIVE HEART FAILURE, ASPIRATION PNEUMONIA</b> |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>J. H. Davis, MD</b>   |  | 29c. LICENSE NUMBER<br><b>D 26571</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/16/91</b>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>IRVING MIZUS MD 5413 CEDAR LANE BETHESDA, MD 20814</b>  |  |  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 20 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1975-1976

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLARA EULALIA MATTINGLY NELSON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUG. 7, 1991</b>   |  | 3. TIME OF DEATH<br><b>3:00 P.M. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-36-7442</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. 12, 1899</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. MARY'S NURSING CENTER</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LEONARDTOWN</b>  |  |
| 9c. COUNTY OF DEATH<br><b>ST. MARY'S CO.</b>  |  |  |  | 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>ST. MARY'S</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>MECHANICSVILLE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>GENERAL DELIVERY</b>  |  |
| 10f. ZIP CODE<br><b>20659</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH. GRADE</b><br>College (1-4 or 5+) <b>HOUSEWIFE</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BERNARD EUGENE MATTINGLY</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CLIFFIE MAY CRYER</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>AGNES NAOMI MATTINGLY</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>GENERAL DELIVERY, LEONARDTOWN, MARYLAND 20650</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. JOSEPH'S CEMETERY 8/10/91</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>MORGANZA, MARYLAND</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>David A. Simmons</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>MATTINGLEY-GARDINER FUNERAL HOME, P.A.<br/>P.O. BOX 270, LEONARDTOWN, MD. 20650</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Pulmonary Arrest.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Organic Brain Syndrome</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>28b. TIME OF INJURY M</b><br><b>28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b><br><b>28d. DESCRIBE HOW INJURY OCCURRED</b><br><b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Julia Davidson-Wendell</i><br><b>29c. LICENSE NUMBER</b><br><b>29d. DATE SIGNED (Month, Day, Year)</b><br><b>8/8/91</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DAVID FEDERLE, M.D. P.O. BOX 457, LEONARDTOWN, MARYLAND 20650</b>   |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>AUG 12 '91</b>  |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Wendell</i>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James Wesley Nicholson   |  |   |  | 2. DATE OF DEATH<br>MONTH 8 DAY 14 YEAR 91  |  | 3. TIME OF DEATH<br>2:20 PM  |  |
| 4. SOCIAL SECURITY NUMBER<br>578-22-9436   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>65 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>09/20/25  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Winchester, VA   |  |   |  | 9. COUNTY OF DEATH<br>Prince George's   |  |  |  |
| 10. FACILITY NAME (If not institution, give street and number)<br>Leland Memorial Hospital   |  |   |  | 11. CITY, TOWN OR LOCATION OF DEATH<br>Riverdale  |  |  |  |
| 12. RESIDENCE OF DECEDENT<br>10a. STATE Maryland 10b. COUNTY Prince George's 10c. CITY, TOWN OR LOCATION Riverdale 10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER 5811 63rd Place 10f. ZIP CODE 20737 10g. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc. Specify: White                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) 7th College (1-4 or 5+) ———   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Machinist Mechanic  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Manufacturing & Construction  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John W. Nicholson   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Susie A. Woodward  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mary A. Nicholson  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5811 63rd Place, Riverdale, Maryland 20737   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Ft. Lincoln Cemetery  |  | 20c. LOCATION — City or Town, State<br>Brentwood, Maryland  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>[Signature]   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Francis Gasch's Sons Funeral Home, PA<br>4739 Baltimore Ave., Hyattsville, MD 20781   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiopulmonary Arrest</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Acute Myocardial Infarction</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>Coronary Artery Disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u>Renal Failure with Hyperkalemia</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Atherosclerotic Cardiovascular Disease</u><br><u>Diabetes Mellitus</u>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY M   |  | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]  |  | 29c. LICENSE NUMBER<br>D22549   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/14/91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>G.M. DIN, M.D. 6510 Kenilworth Ave Suite 2610 Riverdale, MD 20737   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 16 91   |  | 32. REGISTRAR'S SIGNATURE<br>[Signature]  |  |   |  |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be retained for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

12

PLATE 19

91 23757

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alma Willena NICHOLLS</b>   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 7 1991</b>                   |  | 3. TIME OF DEATH<br>HOURS MINUTES AM/PM<br><b>9:45 A M</b>                                      |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579 44 0745</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>58</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JAN 8, 1933</b>                 |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>WASH. D.C.</b>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Doctors Community Hospital</b>  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Lanham</b>                         |  | 9c. COUNTY OF DEATH<br><b>Prince George</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGES</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>LANHAM, MD</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7935 JOHNSON AVE # 1012</b>   |  |  |  | 10f. ZIP CODE<br><b>20785</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>EXAMINER</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>EXAMINER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>GOVERNMENT</b>                          |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>DANIEL JEROME HARRIS</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BERTHA TURNER</b>    |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RICHARD E. NICHOLLS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7935 JOHNSON AVE #1012 LANHAM, MD</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CEDAR HILL</b>  |  | 20c. LOCATION — City or Town, State<br><b>8/12/91 SUITLAND, MD</b>           |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ralph Williams</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>RALPH WILLIAMS FUNERAL SVC<br/>719 KENNEDY ST. N.W.</b>  |  |  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic Cancer, Extensive, with</b>   |  |  |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |   |  |
| b. <b>Multisystem Involvement, unknown primary</b>   |  |  |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |   |  |
| c. <b>Spontaneous</b>  |  |  |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |   |  |
| d.   |  |  |  |   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>N/A</b>   |  |  |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J.L. August</i>  |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D15558</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/7/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S.C. ARYANGAT, MD 3308 PERRY STREET, MT. RAINIER, MD 20712</b>   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital, and the funeral director, page 5 should be detached for use in the funeral-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1968 12

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Andrew K. Openchowski   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Aug. 11, 1991  |  | 3. TIME OF DEATH<br>12:10 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>061-28-8291  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 8, 1914  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Germany  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Manor Care, Wheaton   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Wheaton   |  | 9c. COUNTY OF DEATH<br>Montgomery   |  |
| 10a. STATE  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Washington, D.C.   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>3001 VEAZEY TERRACE, NW<br>3001 Verzey Terrace, N.W.   |  | 10f. ZIP CODE<br>20008  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Executive   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Aerospace Engineer  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Maurycy Openchowski  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Janina Weisblat   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Helena Openchowski (Wife)   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3001 VEAZEY TERRACE NW<br>3001 Verzey Terr., N.W. Wash.D.C. 20008   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Comfort Crematory 8-22  |  | 20c. LOCATION — City or Town, State<br>Alex. VA.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Verney Simmons</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br>Joseph Gawler's Sons, Inc. N.W.<br>5130 Wisconsin Ave., Wash.D.C. 20016  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>Acute pneumonia</i><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  | Approximate Interval Between Onset and Death<br>72h  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Alzheimer's Disease</i>  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO         |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Myron L. Lenkin MD</i>   |  | 29c. LICENSE NUMBER<br>DD 6674  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>8/12/91  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MYRON L. LENKIN MD 2309 SHOREFIELD RD<br>WHEATON MD Myron Lenkin  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 14 '91   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR



91 23759

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNE O'DONNELL ANNE O'DONNELL</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>16</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>7:20 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>159-22-9284</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5/13/99</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>England</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Kensington</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3000 McComas Avenue</b>   |  |   |  | 10f. ZIP CODE<br><b>20895</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Katie Culliton</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12945 Pickering Dr, Germantown, MD 20874</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Royal Cemetery</b>  |  | DATE<br><b>8-20</b>   |  | 20c. LOCATION — City or Town, State<br><b>Glenshaw, PA</b>                                      |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>William B. Cull</b> <b>MO0827</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rapp Funeral Services, P.A.</b><br><b>933 Gist Ave, Silver Spring, MD 20910</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Arrest</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Cardiopulmonary Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Aspiration Pneumonitis and</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>PARKINSON'S DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John J. Merendino, M.D.</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D08544</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/16/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John J. Merendino, M.D. 4701 Randolph Rd #216, Rockville, MD 20852</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 19 '91</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rodella</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE REGISTRAR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23760

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DANEE DENISE OLIVE   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>7-27-91   |  | 3. TIME OF DEATH<br>0715A M   |   |
| 4. SOCIAL SECURITY NUMBER<br>—   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>0 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>7-27-91  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Holy Cross Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Silver Spring   |  | 9c. COUNTY OF DEATH<br>Montgomery   |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Silver Spring  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>1518 November Circle, #402   |  | 10f. ZIP CODE<br>20904   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |   |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0<br>College (1-4 or 8+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>N/A  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>N/A   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Anthony Fergerson   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Carole Denise Olive  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Carole Denise Olive (mother)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as #10  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Suburban Crematory   |  | 20c. LOCATION — City or Town, State<br>Silver Spring, MD  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>D. B. Ell M00827  |  | 22. NAME AND ADDRESS OF FACILITY<br>Rapp Funeral Services, P.A.<br>933 Gist Avenue, Silver Spring, MD 20910  |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <u>Extreme Immaturity 480 grams birth weight 23 weeks gestation</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Mother is reportedly HIV antibody positive</u>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mandak Muller, M.D.   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>7/27/91  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mandak Muller, Holy Cross Hospital, 1500 Forest Glen Rd, Silver Spring Md 20910   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>AUG 19 '91  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100000


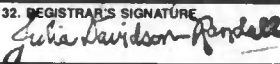
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Arlene Thelma Pollack   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 10, 1991   |  | 3. TIME OF DEATH<br>2:00 a. M  |  |
| 4. SOCIAL SECURITY NUMBER<br>524-28-2822  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>64 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 21, 1927  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Wyoming   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>19309 Dunbridge Way   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Gaithersburg  |  |
| 9c. COUNTY OF DEATH<br>Montgomery   |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Montgomery  |  |
| 10c. CITY, TOWN OR LOCATION<br>Gaithersburg   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>19309 Dunbridge Way  |  |
| 10f. ZIP CODE<br>20879  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Administrative  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Education   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Everett E. Winchell  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Edith B. Early   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Sy Pollack  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>same as #10  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Sunset Memorial Gardens 8/15/91  |  | 20c. LOCATION — City or Town, State<br>Greely, Colorado  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>De Vol Funeral Home<br>10 E. Deer Park Dr. Gaithersburg, MD 20877   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ADDISON'S DISEASE   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? F. Mayle<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Michael Anchors, MD, PhD   |  |  |  |
| 29c. LICENSE NUMBER<br>D29730   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8-12-91  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MICHAEL ANCHORS MD 9711 MEDICAL CENTER DR. ROCKVILLE, MD 20850   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 15 '91   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>DIEP C. PHAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> - DAY <b>12</b> - YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>22:00P. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>586-54-8096</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>41</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>02 01 50</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>GAITHERSBURG</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>417 WEST SIDE DR APT 104</b>   |  |  |  |
| 10f. ZIP CODE<br><b>20878</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Viet Nam</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Viet Nam</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Vietnamese</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Dairy Manager</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Grocery Store</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Giap Phan</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Thi - Tuy Nguyen</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Catherine A. Phan</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>417 West Side Dr. Apt. #104 Gaithersburg, MD 20878</b>                                      |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Mary's Cemetery 8/16/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hollidaysburg, PA</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>De Vol Funeral Home</b><br><b>MO0896 Gaithersburg, MD</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>De Vol Funeral Home FOR</b><br><b>Sorge Fun. Hm. Hollidaysburg, Pennsylvania</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br><b>HYPERTENSION</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>ACUTE</b><br><b>INDIST</b>  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8 12 91</b>   |  | 28b. TIME OF INJURY<br><b>8:30P M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURED<br><b>COLLAPSED AT HOME</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>  |  |   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>#10</b>   |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Francis C. Mayhew</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>807099</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/13/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Francis C. Mayhew 8200 Wisconsin Ave Bethesda MD 20814</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>BOYD L. PARKINSON</b><br><b>BOYD LESLIE PARKINSON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>14</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>11:45 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>232-01-8200</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JUNE 18, 1921</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WEST VIRGINIA</b>  |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>   |  |  |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>   |  |  |  | 11. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |  |  |
| 12. STATE<br><b>MARYLAND</b>  |  | 13. COUNTY<br><b>MONTGOMERY</b>  |  | 14. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>  |  | 15. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 16. STREET AND NUMBER<br><b>11495 COLUMBIA PIKE #C-6</b>  |  |  |  | 17. ZIP CODE<br><b>20904</b>  |  | 18. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 19. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 22. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 23. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>12</b>  |  | 24. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>METRO DISTRICT OPERATING MANAGER</b>  |  | 25. KIND OF BUSINESS/INDUSTRY<br><b>WASHINGTON METRO DISTRICT MONTGOMERY WARD</b>   |  |  |  |
| 26. FATHER'S NAME (First, Middle, Last)<br><b>HOLMES C. PARKINSON</b>   |  |  |  | 27. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VIRGIE BAYER</b>  |  |  |  |
| 28. INFORMANT'S NAME (Type/Print)<br><b>JANET L. PARKINSON (WIFE)</b>   |  | 29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11495 COLUMBIA PIKE#C-6 SILVER SPRING, MARYLAND 20904</b>   |  |   |  |  |  |
| 30. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>REST HAVEN CEMETERY</b>   |  | 32. DATE<br><b>8/17</b>   |  | 33. LOCATION — City or Town, State<br><b>HAGERSTOWN, MARYLAND</b>  |  |
| 34. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Francis J. Collins</i>  |  | 35. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>   |  |   |  |  |  |
| 36. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Chronic lymphocytic leukemia</b> |  |  |  |   |  |  |  |
| 37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |
| 38. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 39. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 40. 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 41. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 42. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 43. 28a. DATE OF INJURY (Month, Day, Year)   |  | 44. 28b. TIME OF INJURY<br><b>M</b>   |  | 45. 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 46. 28d. DESCRIBE NOW INJURY OCCURRED   |  | 47. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 48. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 49. 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 50. SIGNATURE AND TITLE OF CERTIFIER<br><i>John J. Merendino</i>  |  |  |  | 51. 29c. LICENSE NUMBER<br><b>D 08544</b>   |  | 52. 29d. DATE<br><b>8/14/91</b>  |  |
| 53. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 29) (Type, Print)<br><b>JOHN J. MERENDINO, M.D. 4701 RANDOLPH RD. #216 ROCKVILLE, MD. 20852</b>   |  |  |  |   |  |  |  |
| 54. DATE FILED (Month, Day, Year)<br><b>AUG 16 '91</b>  |  | 55. 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

| REGISTRATION   |  |  |  |   |  | CERTIFICATE OF DEATH  |  | REG. NO.  |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Jacqueline Barbara Parkman</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 16, 1991</b>                                |  | 3. TIME OF DEATH<br><b>6:00 A M</b>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>544-32-0227</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Aug. 12, 1932</b>                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Oregon</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3508 King William Drive</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney</b>   |  |   | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                   |   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Olney</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>3508 King William Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>20832</b>   |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                      |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Consultant</b>  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Cancer Research Planning</b>          |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Lincoln Cline</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Virginia Schmidt Cruze</b>          |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Donald N. Parkman</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3508 King William Drive, Olney, Maryland 20832</b>  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc. 8/20/91</b>               |  |   | 20c. LOCATION — City or Town, State<br><b>Bethesda, Maryland</b> |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/Rockville, Inc.<br/>300 West Montgomery Avenue<br/>Rockville, Maryland 20850-2805</b>  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <b>Metastatic Carcinoma of the Left Kidney</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death: <b>3 years</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |   |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>James A. Brown, M.D.</b>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D07285</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>August 16, 1991</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>James A. Brown, M.D. 14808 Physicians Lane, Rockville, Maryland 20850</b>  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 19 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |  |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LIDIA CARMEN PEREZ</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>16</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>7:15 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-94-2400</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>30</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JAN. 9, 1961</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NICARAGUA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1902 BRIGHT LEAF COURT</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1902 BRIGHT LEAF COURT</b>  |  |
| 10f. ZIP CODE<br><b>20902</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>NICARAGUA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify:<br><b>NICARAGUAN</b>   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>REGISTRAR</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>ADAMS MORGAN CLINIC</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ALFONSO CHAVEZ</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>DAISY LUGO</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARVIN F. PEREZ (HUSBAND)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1902 BRIGHT LEAF COURT SILVER SPRING, MARYLAND 20902</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY 8/21</b>   |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BOULEVARD, W. SILVER SPRING, MD.</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or final failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE STAB AND CUTTING WOUNDS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated event resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>08/16/1991</b>  |  | 28b. TIME OF INJURY<br><b>7:15 PM</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT STABBED</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>PRIVATE RESIDENCE</b>   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>1902 BRIGHT LEAF COURT, SILVER SPRING, MARYLAND</b>  |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/17/1991</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 PENN STREET BALTIMORE, MARYLAND 21201</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 20 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

FOR HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dora Belle Pierce  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 11, 1991  |  | 3. TIME OF DEATH<br>12:10 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>070-30-7489   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>55 YRS.   |  |
| 7. DATE OF BIRTH<br>MONTH DAY YEAR<br>April 20, 1936   |  | 8. BIRTHPLACE (State or Foreign Country)<br>New York   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3500 Dixon Street  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Temple Hills  |  | 9c. COUNTY OF DEATH<br>Prince George's  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Prince George's   |  | 10c. CITY, TOWN OR LOCATION<br>Temple Hills   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>3500 Dixon Street  |  | 10f. ZIP CODE<br>20748  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>6/29/54 - 5/7/55  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) College  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>N/A  |  | 17. FATHER'S NAME (First, Middle, Last)<br>Jesse Shepherd   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Florence Maude Bigelow  |  | 19a. INFORMANT'S NAME (Type/Print)<br>Harvey W. Pierce   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3500 Dixon St., Temple Hills, Maryland 20748   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arlington National Cem. 8/15/91   |  | 20c. LOCATION — City or Town, State<br>Arlington, Virginia  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George P. Kalas</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br>George P. Kalas Funeral Home<br>6160 Oxon Hill Rd. Oxon Hill, Md. 20745  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Breast Cancer, metastasized to bone &amp; bone marrow</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  | Approximate Interval Between Onset and Death<br>10 years   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Takuo Sonoda</i>   |  | 29c. LICENSE NUMBER<br>TN MD 008626   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>12 Aug 91   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Malcolm Grow Medical Center<br>Takuo Sonoda, M.D. Col. U.S.A.F. Andrews Air Force Base, Md.   |  | 31. DATE FILED (Month, Day, Year)<br>AUG 14 '91   |  |
| 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS: 23, 27 per ME  
G-679 9/6/91 cm

91-4475-510

91 23767

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Grayling Pugh</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 03 1991</b>  |  | 3. TIME OF DEATH<br><b>4:45 P M</b>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>79-72-2692</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>36</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10-4-54</b>  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shock Trauma Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH<br><b>Maryland</b>  |  |  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Prince George</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hillcrest, Maryland</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br><b>4013-21th Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>20743</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Yes</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Clerk</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Veteran Administration</b>  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John H Pugh</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lucille BRIDGES (Deceased)</b>   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Juan Pugh</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>722 Girard St. N.W., Wash. D.C. 20009</b>  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHELTENHAM CEMETARY 8/14</b>   |  | 20c. LOCATION — City or Town, State<br><b>CHELTENHAM MD</b>  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Taylor Funeral Service 225 Missouri Ave. N.W. 20011</b>   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>INTRACEREBRAL HEMORRHAGE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>OUT TO (OR AS A CONSEQUENCE OF):</b><br>c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br>d. |  |  |  |  |  |   |  | Approximate interval between Onset and Death |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |  |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GOLUB, JR. MD 111 Penn Street, Baltimore Maryland 21201</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08 04 1991</b>  |  |  |  |
| 31. DATE OF FILING (Month, Day, Year)<br><b>AUG 13 1991</b>  |  |  |  |  |  |   |  |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |
|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>CHARLES COLE PRYOR</b><br><b>CHARLES PRYOR</b>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 9 91</b>  |   | 3. TIME OF DEATH<br><b>2:35 P M</b>                  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-07-2048</b>  | 5. SEX<br><b>1 M 2 F</b>   | 6. AGE (In yrs. last birthday)<br><b>93 YRS.</b>   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 12, 1897 Maryland</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>Leland Memorial Hospital</b>   |   |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>RIVERDALE</b>  |  | 11. COUNTY OF DEATH<br><b>PRINCE GEORGE</b>  |   |  |
| 12a. STATE<br><b>MD</b>  | 12b. COUNTY<br><b>PRINCE GEORGE</b>  | 12c. CITY, TOWN OR LOCATION<br><b>HYATTSVILLE</b>  |   | 12d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>        |
| 13. STREET AND NUMBER<br><b>1412 Ray Road</b>  |  | 14. ZIP CODE<br><b>20782</b>   |   | 15. CITIZEN OF WHAT COUNTRY?<br><b>United States</b> |
| 16. MARITAL STATUS<br><b>XX Never Married 2 Married</b><br><b>3 Widowed 4 Divorced</b>   | 17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES<br><b>YES- WW-2</b> |  | 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify: <b>NO</b> |  |
| 19. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 20. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>8th</b>  |   |  |
| 21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>mechanic</b>   |  | 22. KIND OF BUSINESS/INDUSTRY<br><b>aircraft company</b>   |   |  |
| 23. FATHER'S NAME (First, Middle, Last)<br><b>Charles H. Pryor</b>   |  | 24. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alice May Cole</b>   |   |  |
| 25. INFORMANT'S NAME (Type/Print)<br><b>Ms. Charlotte A. Pryor</b>   |  | 26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>621 Elmwood Street, State College, Pa. 16801</b>  |   |  |
| 27. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State</b><br><b>4 Donation 5 Other (Specify)</b>   |  | 28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cemetery 08-13-91 Baltimore, Maryland</b>         |   |  |
| 29. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Francis Gasch</b>  |  | 30. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A.<br/>4739 BALTIMORE AVE., HYATTSVILLE, MD. 20781</b>                   |   |  |
| 31. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>b. Arteriosclerotic Cardiovascular Disease</b><br><b>c. PARKINSON'S DISEASE</b><br><b>d. </b> |  |  |   |  |
| 32. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinson's Disease</b>   |  |  |   |  |
| 33. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>  |  | 34. PLACE OF DEATH (Check only one)<br><b>HOSPITAL: 1 Inpatient 2 Outpatient 3 DOA</b><br><b>OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)</b> |   |  |
| 35. MANNER OF DEATH<br><b>1 Natural 5 Pending Investigation</b><br><b>2 Accident 6 Could not be determined</b><br><b>3 Suicide 4 Homicide</b>  |  | 36. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>  |   |  |
| 37. TIME OF INJURY<br><b>M</b>   |  | 38. INJURY AT WORK?<br><b>1 YES 2 NO</b>   |   |  |
| 39. DESCRIBE HOW INJURY OCCURRED   |  | 40. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |
| 41. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  |  |   |  |
| 42. SIGNATURE AND TITLE OF CERTIFIER<br><b>Paul A. DeVore, Deputy Medical Examiner</b>   |  | 43. LICENSE NUMBER<br><b>501852</b>  |   | 44. DATE SIGNED (Month, Day, Year)<br><b>8-9-91</b>  |
| 45. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PAUL A. DEVORE, MD 4203 Queensbury Rd Hyattsville MD 20781</b>   |  |  |   |  |
| 46. DATE FILED (Month, Day, Year)<br><b>AUG 11 '91</b>   |  | 47. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 17

See page 17

91-4570-033

91 23769

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |   |   |
|--|--|---|---|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Demetrus Penn</b>   |  |   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 09 1991</b>   |  | 3. TIME OF DEATH<br><b>4:29 A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>4 Mos</b> YRS. |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 18, 1991</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Wash. D.C.</b> |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Malcolm Grow Hospital</b>   |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Camp Springs</b>  |  | 9c. COUNTY OF DEATH<br><b>Prince George</b>   |   |
| 10a. STATE<br><b>D.C.</b>  |  | 10b. COUNTY<br><b>District</b>  |   | 10c. CITY, TOWN OR LOCATION<br><b>Washington</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>800 55th St. N.E.</b>   |  |   |   | 10f. ZIP CODE<br><b>20019</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  |   |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Donald Penn</b>  |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth Penn</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth Penn</b>   |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>800 55th St. N.E., Wash. D.C. 20019</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Cemetery 8/13 Landover, MD</b>   |   | 20c. LOCATION — City or Town, State   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John T. Stewart III</b>  |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br><b>Stewart Funeral Home<br/>4001 Benning Rd. N.E. Wash. D.C. 20019</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SUDDEN INFANT DEATH SYNDROME</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |   |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |   |   |  |   |   |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |   |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> XER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Donald G. Wright</b>   |  |   |   | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08 09 1991</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Donald G. Wright, MD DCME 111 Penn Street, Baltimore Maryland 21201</b>  |  |   |   |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 12 91</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |   |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN PORTER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>18</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>11:37 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>223-18-6626</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. NOV. 30. 1914</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA GENERAL HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>VIRGINIA</b>   |  | 10b. COUNTY<br><b>ACCOMACK. CO.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>SAXIS</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                  |  |
| 10e. STREET AND NUMBER<br><b>SAXIS ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>23427</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br><b>WW 11</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                               |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>GRAD 11th</b><br>College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>BOOKKEEPER &amp; TRUCKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PORTER BROS. TRUCKING CO.</b>                                    |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HARRY T. PORTER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>EMMA DENNIS</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JUANITA MILES PORTER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAXIS ROAD, SAXIS, VA. 23427</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, etc.)<br><b>TAYLOR MEMORIAL CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>OAK HALL, VA 23416</b>  |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Laura N. Fox</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FOX FUNERAL HOME<br/>P.O. BOX 278 TEMPERANCEVILLE, VA 23442</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Larger Bowel Infarction</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Atherosclerotic Cardiovascular Disease</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>days</b><br><b>years</b>                           |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                      |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John T. Porter, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D36783</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/18/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John T. Porter, M.D. Peninsula General Hospital, Salisbury, MD</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED<br><b>AUG 20 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARTHA ELIZABETH POLK  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>AUGUST 14, 1991   |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-05-3273   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>APRIL 23, 1916   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>PENINSULA GENERAL HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SALISBURY  |  | 9c. COUNTY OF DEATH<br>WICOMICO   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>MD.  |  | 10b. COUNTY<br>WICOMICO  |  | 10c. CITY, TOWN OR LOCATION<br>EDEN   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>308 POSTOFFICE ROAD  |  |  |  | 10f. ZIP CODE<br>21822  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th  |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>LABORER  |  | 19b. KIND OF BUSINESS/INDUSTRY<br>DEERS STATE CENTER  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>SAMUEL CHURCH   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ANNIE HANDY  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>AGNES RANDALL  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>119 DORSEY DR., ANNAPOLIS, MD. 21031   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>SPRINGHILL, MEMORY GARDEN  |  | 20c. LOCATION — City or Town, State<br>HEBRON, MD.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles D. Jolley</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>JOLLEY MEMORIAL CHAPEL, RTE. 2, BOX 920<br>SALISBURY, MD. 21801   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Myocardial Infarction</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <i>Chronic Coronary Artery Disease</i><br>b. DUE TO (OR AS A CONSEQUENCE OF): <i>Thrombosis</i><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Degenerative Arteriosclerosis</i>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)<br><i>In Automobile</i> |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>8/14/91   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><i>No Injury</i>   |  | 28d. DESCRIBE NOW INJURY OCCURRED<br><i>Time Death 11:53</i>   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles D. Jolley</i>  |  | 29c. LICENSE NUMBER<br>A-10891  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/15/91  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Bill C. Eastern Shore Drug Sales Inc. 21501</i>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 16 '91  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


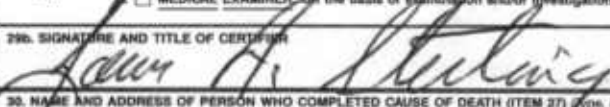
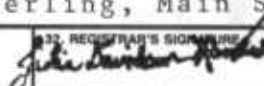
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |  |  |
|--|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Margaret B. Phillips   |  |  |   | 2. DATE OF DEATH<br>MONTH 8 - DAY 13 - YEAR 91  |  | 3. TIME OF DEATH<br>8:47 a. m.   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-07-3084   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>73 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>8-15-17   |  | 8. BIRTHPLACE (State or Foreign Country)<br>VIRGINIA                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Edw.W.McCready Mem. Hospital   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Crisfield  |  | 9c. COUNTY OF DEATH<br>Somerset  |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |  |  |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>SOMERSET  |   | 10c. CITY, TOWN OR LOCATION<br>CRISFIELD  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>HALL HIGHWAY   |  |  |   | 10f. ZIP CODE<br>218  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Years<br>College (1-4 or 5+) _____  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>N/A                             |   | 16b. KIND OF BUSINESS/INDUSTRY<br>N/A   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Ray Phillips  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Margurite B. Blundon   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ROBERT W. PHILLIPS   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 366 Nags Head, NC 27959   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____   |  |  |   | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>PARSONS CEMETERY  |  | 20c. LOCATION — City or Town, State<br>SALISBURY, MARYLAND                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Holloway Funeral Home, Salisbury, Md. 21801   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |   |   |  |  |  |
| a. <i>congestive heart failure</i>   |  |  |   |   |  |  |  |
| b. <i>ASCVD</i>  |  |  |   |   |  |  |  |
| c. _____   |  |  |   |   |  |  |  |
| d. _____   |  |  |   |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |   |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>chronic schizophrenia</i>   |  |  |   |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) _____ |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |   | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M _____   |  |
|  |  |  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
|  |  |  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)             |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br>Dr. James Sterling   |  |  |   | 29c. LICENSE NUMBER<br>D10214   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8-16-91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. James Sterling, Main St., Crisfield, Md. 21817  |  |  |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 16 91   |  |  |   | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

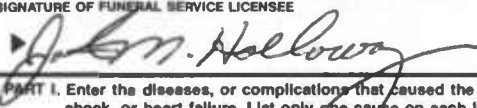
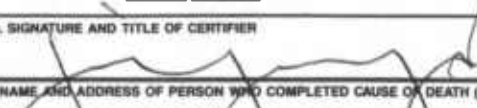
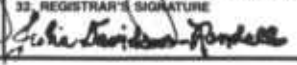
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Gloria L. Porter   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>8/14/ 91  |  | 3. TIME OF DEATH<br>4:30 A M  |   |
| 4. SOCIAL SECURITY NUMBER<br>220-52-8459 A   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>42 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>1-27-49   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  |  |  |   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Deers Head Center  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Salisbury, MD.   |  | 9c. COUNTY OF DEATH<br>Wicomico   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>WICOMICO  |  | 10c. CITY, TOWN OR LOCATION<br>SALISBURY  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>ETON COURT   |  |  |  | 10f. ZIP CODE<br>21801  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12 Years  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>SECRETARY  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>LEGAL   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>MERVIN M. PILCHARD  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ERNESTINE (UNK) HUDSON   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>ROBERT GEORGE PORTER   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 1365 Salisbury, MD 21801  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 8-16-91  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>WICOMICO MEMORIAL PARK  |  | 20c. LOCATION — City or Town, State<br>SALISBURY, MARYLAND  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HOLLOWAY FUNERAL HOME<br>501 SNOW HILL RD. SALISBURY, Md. 21801   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY ARREST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST } b. MULTIPLE SCLEROSIS<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>D28542   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/14/91  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. EVANGELISTA P.O. Box 2018- Salisbury, Md. 21802   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>AUG 16 '91  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Teresa Lucia Paparella</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 14 1991</b>  |  | 3. TIME OF DEATH<br><b>10:45 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-70-5851</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>35 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-7-1956</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>715 Edgewater Dr Apt 104</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>   |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Wicomico</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>715 Edgewater Dr. Apt 104</b>   |  |  |  | 10f. ZIP CODE<br><b>21801</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Social Worker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Creative Child Care</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Michael W. Paparella</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Alice Deegan</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Michael W. Paparella</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>715 Edgewater Dr. Apt 104, Salisbury, MD</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Springhill Memory GDNS</b>  |  | 20c. LOCATION — City or Town, State<br><b>Hebron, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Guald C Brunel</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bounds FH 705 E Main St Salisbury, MD</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>metastatic Breast Ca</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph A. Grasso M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>020507</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/14/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Joseph A. Grasso 145 E. CARROLL ST Salisbury MD</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 '91</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Lelia Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23776

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Thomas Earl Quade   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 24, 1991   |  | 3. TIME OF DEATH<br>1425pm   |   |
| 4. SOCIAL SECURITY NUMBER<br>577 03 0956  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>8 25 15  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Calvert Memorial Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Prince Frederick   |  | 9c. COUNTY OF DEATH<br>Calvert   |   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Calvert   |  | 10c. CITY, TOWN OR LOCATION<br>Solomons   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10a. STREET AND NUMBER<br>Patuxent Ave.   |  |  |  | 10f. ZIP CODE<br>20688  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>steamfitter  |  | 17. KIND OF BUSINESS/INDUSTRY<br>construction   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Arthur Quade   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary C. Carroll  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Linda Mathers   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1032 Christmas Lane Gambrills Maryland 21054   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metropolitan Funeral Service  |  | 20c. LOCATION — City or Town, State<br>Alexandria Virginia  |  | 20d. DATE<br>8 25 91   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>B. Rausch  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Rausch Funeral Home<br>4405 Broomes Is. Rd. Port Republic Maryland  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Parkinsonism<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Previous strokes<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation<br>6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO    |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)             |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Charles Bennett M.D.   |  |  |  | 29c. LICENSE NUMBER<br>025156   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/24/91   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Charles Bennett M.D., Lusby, Md. 20657   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>AUG 26 1991  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM FRANKLIN ROBEY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>14</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>2:02 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-58-2169</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>41</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 7, 1950</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>   |  | 8c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| 9a. RESIDENCE OF DECEDENT<br>10a. STATE<br><b>MARYLAND</b>   |  |  |  | 10b. COUNTY<br><b>ST. MARY'S COUNTY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>MECHANICSVILLE</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>2230 TIN TOP SCHOOL ROAD</b>   |  |  |  |
| 10f. ZIP CODE<br><b>20659</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>7 YEARS</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>PRIEST</b>  |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>CHURCH</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HUBERT ISHAM ROBEY</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>NANCY ANN GROOMS</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LAURA K. ROBEY</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2230 TIN TOP SCHOOL RD., MECHANICSVILLE, MD. 20659</b>                                    |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. MARK'S EPISCOPAL CEM. 8/17/91</b>  |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MD.</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MATTINGLEY-GARDINER FUNERAL HOME, P.A.<br/>P.O. BOX 270, LEONARDTOWN, MD. 20650</b>                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael K. Gardiner</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MATTINGLEY-GARDINER FUNERAL HOME, P.A.<br/>P.O. BOX 270, LEONARDTOWN, MD. 20650</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>TENSION PNEUMOTHORAX 2° TO RESPIRATORY THERAPY</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. <b>PNEUMOCYSTIS CARNI PNEUMONIA</b><br>c. <b>Acquired Immunodeficiency Syndrome</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>2 WEEKS</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8-14-91</b>  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Arnold G. Levy MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D15790</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-14-91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Arnold G. Levy MD 1106 SPRING ST., SILVER SPRING, MD 20910</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for registration, certification, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LUCILLE RICHARDSON</b>   |  | 2. DATE OF DEATH (Month, Day, Year)<br><b>08 17 91</b>   |  | 3. TIME OF DEATH<br><b>0710 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-07-5557</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>07-18-12</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>S. Carolina</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Adventist Hosp</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville MD</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Germantown</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>18642 Sage way</b>  |  | 10f. ZIP CODE<br><b>20874</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><input type="checkbox"/> Elementary/Secondary (0-12) <b>12 Grade</b><br><input type="checkbox"/> College (1-4 or 8+) |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KING OF BUSINESS/INDUSTRY<br><b>None</b>  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Waller</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hattie Jones</b>  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr Christopher Richardson</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19642 Sage Way, Germantown, Md #20874</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Rockville, Md</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George R. Snowden</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SNOWDEN FUNERAL HOME P.A. 20850<br/>246 N. Washington St, Rockville, Md</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Suspected perforated bleeding ulcer</b><br><i>Suspected perforated bloody ulcer</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>vs. ischemic bowel disease</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Ischemic Bowel disease</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  | Approximate Interval Between Onset and Death<br><b>hours</b>   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>asymptomatic melanoma</b><br><b>Diabetes Mellitus with nephropathy, neuropathy, retinopathy</b><br><b>Chronic Artery disease</b>   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Asst. Comm. MD VINITSKY</i>   |  | 29c. LICENSE NUMBER<br><b>D22180</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/17/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ARM &amp; VINITSKY, 902 WINDRIVER LANE SUITE 201 GAITHERSBURG MD 20878</b>  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 19 '91</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

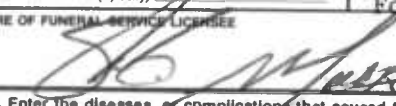

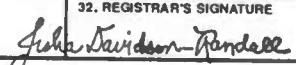
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11 - 12

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JACK ROGERS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>7:40AM</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-10-6365</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6/1/1914</b>  |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>PRINCE GEORGE'S HOSPITAL CENTER</b>  |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>CHEVERLY</b>   |  | 10. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>Prince George's</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Colmar Manor</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4303 Monroe Street</b>  |  |  |  | 10f. ZIP CODE<br><b>20722</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinist</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Altamont M. Rogers</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nellie Koerner</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Katherine B. Rogers</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7401 New Hampshire Ave., Apt. #204, Hyattsville, Maryland 20783</b>                         |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>  |  | DATE<br><b>8-14</b>   |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD., 20722</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | <b>RESPIRATORY FAILURE</b>   |  |   |  | Approximate Interval Between Onset and Death<br><b>40 MIN.</b>                                  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | <b>BRAIN TUMOR</b>   |  |   |  | <b>5 WEEKS</b>  |  |
|  |  |  |  |   |  |   |  |
|  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>KLEBSIELLA AND PSEUDOMONAS URINARY TRACT INFECTION, ORAL CANDIDIASIS, CORONARY ARTERY DISEASE</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D31345</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-11-91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NAPOLEON C. MARCELO, MD 9801 GREENBELT RD #212 LANHAM, MD 20706</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 '91</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or funeral home. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Marie C. Reinhart  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 12, 1991   |  |  |  | 3. TIME OF DEATH<br>7:50 A. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>579-40-5888   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 1, 1909                              |  | 8. BIRTHPLACE (State or Foreign Country)<br>Washington, D.C.   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Carriage Hill Nursing Center   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Silver Spring  |  |  |  | 9c. COUNTY OF DEATH<br>Montgomery  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Prince Georges  |  | 10c. CITY, TOWN OR LOCATION<br>Forestville  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>2811 West Ave.   |  |  |  | 10f. ZIP CODE<br>20747  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>own home   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Alois J. Reinhart   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna M. Volk   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ota Overall  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2809 West Ave. Forestville, MD. 20747  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery 8/14/91   |  |  |  | 20c. LOCATION — City or Town, State<br>Suitland, MD.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Bryan L. Neubach</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>4308 Suitland Rd.<br>Robert E. Wilhelm, Inc. Suitland, MD. 20746  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <i>Coronary artery disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death |  |  |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension, Diabetes mellitus, atherosclerosis</i>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Don. J. J. [Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br>D17131  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>8/13/91   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 14 '91  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Olevia Rossiter</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 16 1991</b>   |  | 3. TIME OF DEATH<br><b>9:20 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>221-12-4491</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12/13/1909</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harrison House Nursing Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Snow Hill</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Worcester</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Worcester</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Pocomoke</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>Newtown Square Apts. C-2</b>  |  |
| 10f. ZIP CODE<br><b>21851</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>2</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Frederick Burke</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Lida Stant</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shirley Mereider</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rd#1 Box 249N, Bridgeville, Del. 19933</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>First Baptist Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Pocomoke, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott S. Melson</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Melson Funeral Home<br/>PO Box 64, Pocomoke, Md. 21851</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC OVARIAN CA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>4 yrs</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)                                     |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dorothy C. Holzworth, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 06241</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-16-91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DOROTHY C. HOLZWORTH HARRISON HOUSE SNOW HILL, MD. 21863</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 19 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Eddy J. Rodriguez</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 10 1991</b>  |  | 3. TIME OF DEATH<br>HOUR MIN<br><b>6:45 A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-21-3315</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>24</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Mar. 19, 1967</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Nicaragua</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>3100 Beaverwood Lane</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>305 E. University Blvd.,</b>  |  |
| 10f. ZIP CODE<br><b>20903</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Permanent resident</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify <b>Nicaragua</b>  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 1-12</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Garbage Collector</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Waste Management</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ricardo Arrieta</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nubia Del Socorro</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lileana Rodriguez</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>305 E. University Blvd., Sil. Spr. Md. 20903</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery 8-17-91 Sil. Spr. Md.</b>  |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Clark E. Wilson</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hines/Rinaldi Funeral Home<br/>11800 N.H. Ave., Silver Spring, Md. 20904</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES</b><br><b>Due TO (OR AS A CONSEQUENCE OF):</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b><br>b. <b>Due TO (OR AS A CONSEQUENCE OF):</b><br>c. <b>Due TO (OR AS A CONSEQUENCE OF):</b><br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>24a. WAS AN AUTOPSY PERFORMED?</b><br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br><b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b><br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br><b>HOSPITAL:</b><br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br><b>OTHER:</b><br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>08 10 1991</b>   |  | 28b. TIME OF INJURY<br><b>6:45 A</b>   |  |
| 28c. INJURY AT WORK?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Pedestrian struck by truck</b>   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mario F. Golle, Jr., MD</i>  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>08 10 1991</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore Maryland 21201</b>  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 19 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

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1. 10.



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

REG. NO.

DHMN-16 Rev 1/89

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |
|---|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HILDA TAYLOR</b>   |  | 2. DATE OF DEATH<br>MONTH <b>AUG</b> DAY <b>17</b> YEAR <b>1991</b>  |   | 3. TIME OF DEATH<br><b>1920</b> M   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-07-6276</b>   | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-3-20</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA GENERAL HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>  |   | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |
| RESIDENCE OF DECEDENT   |  |  |   |   |
| 10a. STATE<br><b>MD</b>   | 10b. COUNTY<br><b>WICOMICO</b>   | 10c. CITY, TOWN OR LOCATION<br><b>SALISBURY</b>  |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |
| 10e. STREET AND NUMBER<br><b>1400 RIVERSIDE DRIVE</b>   |  | 10f. ZIP CODE<br><b>21801</b>  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>        |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10 YEARS</b><br>College (1-4 or 5+) <b>HOUSEWIFE</b>  |  | 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UNDERWOOD ROBERTS TAYLOR</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ALLENA S. WATSON</b>   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DALE R. RAYNE</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1400 RIVERSIDE DR. SALISBURY, MD 21801</b>   |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BUCKINGHAM CEMETERY</b>  |   | 20c. LOCATION — City or Town, State<br><b>BERLIN, MARYLAND</b>  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W.R. Kelly</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HOLLOWAY FUNERAL HOME<br/>501 SNOW HILL RD. SALISBURY, MD 21801</b>   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Ovarian Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |   | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|   |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY<br><b>M</b>                       | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David E. Carroll MD</i>  |   |   |
|   |  | 29c. LICENSE NUMBER<br><b>D26278</b>   | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-18-91</b> |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David E. Carroll, MD 145 E. Carroll St. Salisbury, MD 21801</b>   |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 20 91</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John F. ...</i>  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HATTIE ELIZABETH RYCE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 20, 1991</b>   |  | 3. TIME OF DEATH<br>M<br><b>6:44 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-18-8064</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 27, 1917</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>PHYSICIANS MEMORIAL HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LA PLATA</b>   |  |
| 9c. COUNTY OF DEATH<br><b>CHARLES</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>CHARLES</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>IRONSIDES</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>GENERAL DELIVERY</b>  |  |
| 10f. ZIP CODE<br><b>20643</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th GRADE</b><br>College (1-4 or 5+) <b>HOMEMAKER</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>OWN HOME</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM FARRELL</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MABLE BUSSLER</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SIDNEY W. RYCE</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS #10</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHRIST CH. CEMETERY (8-22-91)</b>   |  | 20c. LOCATION — City or Town, State<br><b>WAYSIDE, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael O. Raymond</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>AREHART FUNERAL HOME, INC.<br/>LA PLATA, MARYLAND 20646</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic cardiac vascular disease</b> <b>May yrs.</b>   |  |  |  |  |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| b. <b>Left sided CVA</b> <b>yrs.</b>   |  |  |  |  |  |  |  |
| c. <b>Diabetes Mellitus</b> <b>Many yrs.</b>   |  |  |  |  |  |  |  |
| d. <b>UTI</b> <b>3 weeks</b>   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>osteoporosis</b>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Niran Sharma MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 21173</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/20/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Niran Sharma, MD, Pembroke Sq., #104, Hgy. 301 So., Waldorf, Md. 20603</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 21 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23786

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Gladys Ruth Rhoten</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Aug 20 - 1991</b>  |  | 3. TIME OF DEATH<br>M<br><b>2 A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-05-0321</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>1-5-02</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  | 9. COUNTY OF DEATH<br><b>Carroll</b>  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3191 Main St (Residence)</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Manchester</b>  |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Carroll</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Manchester</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3191 Main St</b>   |  |   |  | 10f. ZIP CODE<br><b>21103</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sewing factory</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Sewing factory</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elva Davidsson</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lyla Graso Hann</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LESTER RHOTEN JR.</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2332 BACHMAN VALLEY RD, Manchester, MD 21102</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CEM. 8-23-91</b>  |  | 20c. LOCATION — City or Town, State<br><b>HAMPSTEAD MD.</b>   |  | 20d. DATE<br><b>8-23-91</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>J. Darth Eckhardt</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ECKHARDT FUNERAL CHAPEL<br/>3296 CHARMIL DRIVE MANCHESTER MD 21102</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>arteriosclerotic Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Wilbur H Foard MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D02386</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/20/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Wilbur H Foard MD 3223 Main St Box 50 Manchester, MD 21102</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 21 '91</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1915

1. The first part of the report deals with the general situation of the country. It is a very interesting and valuable contribution to the knowledge of the country and its people. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a pleasure to read. It is a very valuable contribution to the knowledge of the country and its people. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a pleasure to read.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and valuable contribution to the knowledge of the country and its people. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a pleasure to read. It is a very valuable contribution to the knowledge of the country and its people. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is a pleasure to read.

91 23787

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Thomas W. Rawlings</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Aug</b> DAY <b>17</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>9:55 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-12-1125</b>   |  | 5. SEX<br><b>1</b> M <b>2</b> F  |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/11/14</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Bon Secours Hospital</b>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 8c. COUNTY OF DEATH<br><b>Maryland</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Calvert</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Sunderland</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO  |  |
| 10e. STREET AND NUMBER<br><b>180 Wayside Drive</b>  |  |  |  | 10f. ZIP CODE<br><b>20689</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0-4</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b> |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Rawlings</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gertrude Plater</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Doris E. Rawlings</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>180 Wayside Drive, Sunderland, Maryland 20689</b> |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Hope Church Cemetery</b>                      |  | 20c. LOCATION — City or Town, State<br><b>Sunderland, Md</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Spencer L. Sewell</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1451 Dares Beach Rd.<br/>Sewell Funeral Home Prince Frederick, Md</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARRHYTHMIA</b>   |  |  |  |   |  |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| b. <b>PNEUMONITIS</b>   |  |  |  |   |  |   |  |
| c. <b>Old cerebrovascular accident</b>  |  |  |  |   |  |   |  |
| d. <b>Chronic obstructive lung disease</b>  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO  |  | HOSPITAL:<br><b>1</b> Inpatient <b>2</b> Outpatient <b>3</b> DOA   |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)                                    |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>D. Gonzalez Jr MD</b>  |  | 29c. LICENSE NUMBER<br><b>D18711</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/18/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Bon Secours Hospital<br/>2000 W. Baltimore St. Md. 21223</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 20 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FRANCIS WAYNE SMITH</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>12:02 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-44-4147</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F                     |  | 6. AGE (In yrs. last birthday)<br><b>47</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 11, 1944</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY COUNTY</b>   |  |   |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>19308 Muncaster Mill Road</b>  |  |
| 10f. ZIP CODE<br><b>20855</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>                   |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction/Maintenance</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank M. Smith</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bermlie M Joyce</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Cora A. Sheets</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>340 Piney Forest Road, Danville, Va. 24540</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Glenns Chapel Cem. 8-15-91</b>  |  | 20c. LOCATION — City or Town, State<br><b>Rockingham City, N.C.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DeVol Funeral Home<br/>10 E. Deer Park Dr., Gaithersburg, Md. 20877</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Head Injuries</b><br>Approximate Interval Between Onset and Death<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>24a. WAS AN AUTOPSY PERFORMED?</b> <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br><b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b> <b>1</b> <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><b>2</b> <input checked="" type="checkbox"/> Accident<br><b>3</b> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><b>4</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>08/10/91</b>   |  | 28b. TIME OF INJURY<br><b>11:00P</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>AUTO SUBJECT STRUCK BY TRUCK</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b> |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>MUNCASTER AND MUNCASTER MILL ROAD</b>   |  |   |  |
| 29a. CERTIFIER (Check only) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |   |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/12/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. Alan Locke MD 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 91</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


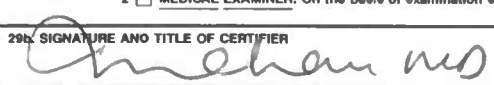
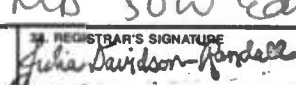
Page 2



91 23789

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SOEBIANT, TJON DRORAHARDJO</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>3.40</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br>Not Applicable   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/10/21</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville Md</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Gaithersburg</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>18245 Lost Knife Circle #201</b>   |  |   |  | 10f. ZIP CODE<br><b>20879</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Indonesia</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Indonesian</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (8-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>12</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life, or last use retired.)<br><b>Broker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Agriculture</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Tjoa Tjwan Tjay</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ang Kiok Nio</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Finawati Tan Swan Liang</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18245 Lost Knife Cr. #201 Gaithersburg, MD 20879</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>De Vol Funeral Home</b><br><b>10 E. Deer Park Dr. Gaithersburg, MD 20877</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. Cardio-pulmonary Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Lung Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Malnutrition</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>R. Hehan MD</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D-33224</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/13/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. Hehan MD 50W Edmonston Dr #504, Rockville MD 20852</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 '91</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOHN ANDREW SMALLWOOD   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>AUG. 23, 1991  |  | 3. TIME OF DEATH<br>12:06 P.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>577-16-7366  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>75 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>MAR. 2, 1916  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>ST. MARY'S HOSPITAL  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>LEONARDTOWN   |  |
| 9c. COUNTY OF DEATH<br>ST. MARY'S COUNTY  |  |  |  | 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>ST. MARY'S COUNTY   |  |
| 10c. CITY, TOWN OR LOCATION<br>CHAPTICO   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>BOX 145  |  |
| 10f. ZIP CODE<br>20621  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>IF YES, GIVE WAR OR DATES<br>WW II  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7TH. GRADE  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>PRESS OPERATOR   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>FEDERAL GOVERNMENT   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN MORRIS SMALLWOOD  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARIE HILL  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>REGENIA M. HAMLIN   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>BOX 145, CHAPTICO, MARYLAND 20621   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MARYLAND VETERAN CEMETERY 8/28/91   |  | 20c. LOCATION — City or Town, State<br>CHELTENHAM, MARYLAND  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>David A. Hamilton</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>MATTINGLEY-GARDINER FUNERAL HOME, P.A.<br>P.O. BOX 270, LEONARDTOWN, MARYLAND 20650  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. CARCINOMA OF LUNG<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br>1 HR<br>3 MONTHS |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CHRONIC OBSTRUCTIVE PULMONARY DISEASE                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert O. Bauer, MD</i>  |  |  |  |
| 29c. LICENSE NUMBER<br>D14168   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/24/91   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>993 OLD RT 5 MECHANICSVILLE, MD 20659  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 27 '91   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Kathleen V. SNOWDEN</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH 8 DAY 9 YEAR 91  |  | 3. TIME OF DEATH<br>7:58 AM   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-26-4848  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>68 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Jan 21, 1923   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  | 9. FACILITY NAME (If not institution, give street and number)<br>Suburban Hospital   |  | 10. CITY, TOWN OR LOCATION OF DEATH<br>Bethesda   |  |
| 11. COUNTY OF DEATH<br>Montgomery   |  |   |  | 12. RESIDENCE OF DECEDENT  |  | 13. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 14. STATE<br>Maryland   |  | 15. COUNTY<br>Montgomery  |  | 16. CITY, TOWN OR LOCATION<br>Silver Spring  |  | 17. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 18. STREET AND NUMBER<br>3411 Norbeck Rd,   |  |   |  | 19. ZIP CODE<br>20906  |  | 20. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 21. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                    |  | 22. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 24. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black   |  |
| 25. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>6th Grade   |  | 26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Cafeteria Worker                       |  | 27. KIND OF BUSINESS/INDUSTRY<br>Montg. County Public Schools  |  | 28. FATHER'S NAME (First, Middle, Last)<br>Joseph Johnson   |  |
| 29. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sarah Lee  |  | 30. INFORMANT'S NAME (Type/Print)<br>Mr Leroy Prather (Son)   |  | 31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13644 Cedar Creek Lane, Silver Spring, Md #20904   |  | 32. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |
| 33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parklawn Memorial Park 8/14   |  | 34. LOCATION — City or Town, State<br>Rockville, Md   |  | 35. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George R. Snowden</i>  |  | 36. NAME AND ADDRESS OF FACILITY<br>SNOWDEN FUNERAL HOME P.A. 20850<br>246 N. Washington St. Rockville, Md  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>ASYSTOLE BRAIN ANOXIA<br><i>Asystole. Brain Anoxia.</i>  |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| CARDIAC ARREST PULMONARY EMBOLUS<br><i>Cardiac Arrest - pulmonary embolus</i>   |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| WOUND ABCESS<br><i>Wound abcess</i>   |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| METASTATIC CANCER OF COLON<br><i>Metastatic Cancer of Colon</i>   |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Subcutaneous Abscess, p drainage</i>   |  |   |  |  |  |   |  |
| 24. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Hospital</i>  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input checked="" type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |
| 28. DATE OF INJURY (Month, Day, Year)<br>N/A  |  | 29. TIME OF INJURY<br>N/A M   |  | 30. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 31. DESCRIBE HOW INJURY OCCURRED<br>N/A   |  |
| 32. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>N/A  |  | 33. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>N/A  |  | 34. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 35. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. R. Thistlethwaite</i>   |  |
| 36. LICENSE NUMBER  |  | 37. DATE SIGNED (Month, Day, Year)<br>8-9-91  |  | 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>J.R. THISTLETHWAITE M.D. 10401 Old Georgetown Rd, Bethesda, Md 20814  |  | 39. DATE FILED (Month, Day, Year)<br>AUG 12 '91   |  |
| 40. REGISTRAR'S SIGNATURE<br><i>John Davidson-Russell</i>   |  |   |  |  |  |   |  |

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

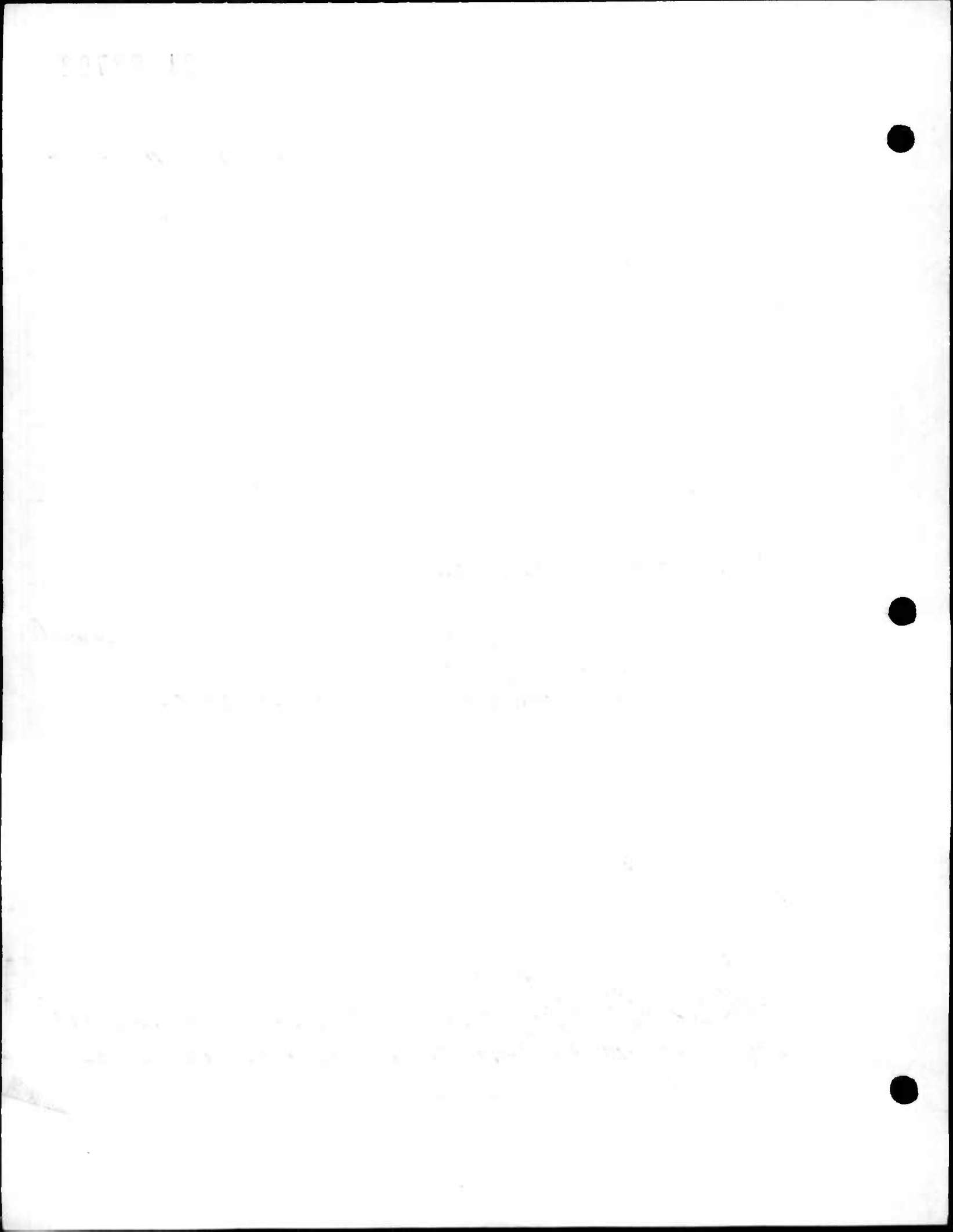
|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Eleanor I. Smith</b>   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>19</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>2:20 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-18-1066</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs., last birthday)<br><b>81</b> YRS.   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12/24/09</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1135 University Blvd. #605</b>   |  | 10f. ZIP CODE<br><b>20902</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Yvonne E. Smith (Daughter)</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12603 Layhill Rd., Silver Spring, MD 20906</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt Zion Cemetery 8/19</b>   |  | 20c. LOCATION — City or Town, State<br><b>Lansdowne, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George R. Snowden</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF) <b>renal failure</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>arteriosclerotic vascular disease</b><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br>27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined<br>28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29b. SIGNATURE AND TITLE OF CERTIFIER<br>29c. LICENSE NUMBER<br><b>D01120</b><br>29d. DATE SIGNED (Month, Day, Year)<br><b>15 Aug 1991</b><br>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WALTER E. GOOZMAN 8309 SHOREFIELD RD WHEATON MD 20902</b><br>31. DATE FILED (Month, Day, Year)<br><b>AUG 19 '91</b><br>32. REGISTRAR'S SIGNATURE<br><b>John Davidson Rodale</b> |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23793

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Hester W. Sebastian   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Aug. 15, 1991   |  | 3. TIME OF DEATH<br>6:55 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>578-07-1271  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Dec. 29, 1914                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br>Silver Spring  |  | 9c. COUNTY OF DEATH<br>Montgomery  |  |
| 9b. FACILITY NAME (If not institution, give street and number)<br>Holy Cross Hospital   |  |  |  | 10a. STATE<br>MD  |  |  |  |
| 10b. COUNTY<br>Montgomery   |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Bethesda   |  |  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>4910 Earlston Drive   |  |  |  |
| 10f. ZIP CODE<br>20816  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) College  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Administrative Ass't.   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Federal Gov't.                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas Benjamin Wright   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nettie Atwell  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Donald A. Sebastian   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10006 Portland Rd., Silver Spring, MD 20901  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Trinity Memorial Gardens  |  | 20c. DATE<br>8/17   |  | 20d. LOCATION — City or Town, State<br>Waldorf, MD                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael E. Nelson</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Joseph Gawler's Sons, Inc.<br>5130 Wisconsin Ave, NW, Washington, DC 20016  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b.<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Tuberculosis</i> |  |  |  |   |  |  | Approximate Interval Between Onset and Death |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Lee R. Boyle</i>  |  |  |  | 29c. LICENSE NUMBER<br>D 15625  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/16/91                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Daniel J. Boyle, M.D., 10313 Georgia Ave., Silver Spring, MD 20902   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 19 91  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23794

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LILLIAN SNIDER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>12</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>7:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-28-3839</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-15-96</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Russia</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1220 East West Hwy. #1418</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1220 East West Hwy. #1418</b>  |  |  |  | 10f. ZIP CODE<br><b>20910</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Jeweler</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Devora "Unknown"</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jerome Snider (son)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3 Arrowood Terrace, Bethesda, Maryland 20817</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Beth Shalom/Nat'l. Capitol Heb. Capitol Heights, MD.</b>        |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Danzansky-Goldberg Memorial Chapels, Inc.<br/>1170 Rockville Pike, Rockville, MD, 20852</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCT</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br><b>CHRONIC ARTERY DISEASE</b><br><br><b>HYPERTENSION; ATRIAL FIBRILLATION</b><br><b>CANCER OF RIGHT BREAST</b> |  |  |  |   |  | Approximate interval Between Onset and Death<br><b>1 DAY</b><br><b>10 YRS</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION; ATRIAL FIBRILLATION</b><br><b>CANCER OF RIGHT BREAST</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> PHYSICIAN   |  |  |  | 29c. LICENSE NUMBER<br><b>D02012 MD</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/13/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DAVID GOLDENBERG, MD. SILVER SPRING, MD. 20902</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

297-48



91 23795

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES W SOPER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 18 1991</b>   |  | 3. TIME OF DEATH<br><b>11:30A<sup>M</sup></b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>190 18 2128</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9 20 1901</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pa.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>University Nursing Home</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SilverSpring,</b>  |   |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>321 UNIVERSITY BOULEVARD, WEST #116</b>   |   |
| 10f. ZIP CODE<br><b>20901</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>SALESMAN</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SALESMAN</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CLYNTON SOPER</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ADA BURLEY</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LILLIAN B. SOPER (WIFE)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>321 UNIVERSITY BLVD., WEST #116 SILVER SPRING, MD. 20901</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>FORT LINCOLN CEMETERY 8/21</b>   |  | 20c. LOCATION — City or Town, State<br><b>BRENTWOOD, MARYLAND</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ALZHEIMER'S DISEASE</b><br><b>HYPERTENSION</b>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D19971</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/18/91</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>K. SUDHAKAR, 2610 CARROLL AVE #230, GAITHERSBURG, MD 20878</b>   |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 20 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10748 17



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Thomas Edgar Sinclair</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>8 14 91   |  | 3. TIME OF DEATH<br>5:30 AM   |   |
| 4. SOCIAL SECURITY NUMBER<br>215-78-3632  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>31 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept: 23, 1959   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Mexico  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>8401 Truck Way (outside)  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Capitol Heights  |   |
| 9c. COUNTY OF DEATH<br>Prince George's  |  |  |  | 10a. STATE<br>Maryland  |  |   |   |
| 10b. COUNTY<br>Prince George's  |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Landover   |  |   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>4719 68th Avenue  |  |   |   |
| 10f. ZIP CODE<br>20784  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |   |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:<br>Peruvian |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                             |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Entrepreneur   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Real Estate   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Walter Ward Sinclair   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elsa Rivera Vega   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Elsa Rivera-Sinclair  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>116 Fleetwood Terrace, Silver Spring, MD 20910   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Suburban Crematory  |  | DATE<br>8-18  |  | 20c. LOCATION — City or Town, State<br>Silver Spring, Maryland                                  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Edwin H. Rapp</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Rapp Funeral Services, P. A.<br>933 Gist Avenue, Silver Spring, MD 20910  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Multiple Gunshot wounds</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>8-14-91 found  |  | 28b. TIME OF INJURY<br>5:15A  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Street   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>In front of 8401 Truck Way Capitol Heights, Md.   |  |   |   |
| 29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Laron Locke M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br>O.C.M.E.   |  | 29d. DATE SIGNED (Month, Day, Year)<br>August 14, 1991  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>J. Laron Locke M.D. 111 Penn St. Baltimore, Md. 21201  |  |  |  | 31. DATE FILED (Month, Day, Year)<br>AUG 19 '91   |  |   |   |
| 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |                                  |   |  |   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
|---|----------------------------------|---|--|---|--|--|--|----------------------------|--------|-----------------------------|---------|----------------------------|------------|----------------------------------|------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LARRY SMITH</b>  |                                  |   |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>4:03 PM</b>   |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-58-7056</b>   |                                  | 5. SEX<br><b>MALE</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br><b>40</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>AUG. 2, 1951</b>                   |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b>   |                                  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                      |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 10a. STATE<br><b>MD</b>   |                                  |   |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>TAKOMA PARK</b>                            |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |                                  |   |  | 10e. STREET AND NUMBER<br><b>8511 FLOWER AVE</b>  |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 10f. ZIP CODE<br><b>20912</b>   |                                  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                                  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>      |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>College</b>   |                                  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>TRANSPORT COORDINATOR</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>ABC NEWS</b>   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES M. SMITH</b>  |                                  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JOAN P. HEDGCOCK</b>  |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 19a. INFORMANT'S NAME (Type, Print)<br><b>JOAN SMITH</b>  |                                  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>317 EAST QUEEN ST., CHAMBERSBURG, PA. 17201</b>   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>   |  | 20c. LOCATION — City or Town, State<br><b>ALEXANDRIA, VA.</b>   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael A. Brown</i>  |                                  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>TAKOMA FUNERAL HOME, INC.</b><br><b>254 CARROLL ST., N.W. WASHINGTON, D.C.</b>   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>hypoxia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><table border="0"> <tr> <td rowspan="4" style="vertical-align: middle; font-size: 3em;">{</td> <td>a. <b>fulminant sepsis</b></td> <td>3 days</td> </tr> <tr> <td>b. <b>immunosuppression</b></td> <td>3 weeks</td> </tr> <tr> <td>c. <b>liver transplant</b></td> <td>3 1/2 mos.</td> </tr> <tr> <td>d. <b>renal failure x 3 days</b></td> <td>3 1/2 mos.</td> </tr> </table> |                                  |   |  |   |  |  | {  | a. <b>fulminant sepsis</b> | 3 days | b. <b>immunosuppression</b> | 3 weeks | c. <b>liver transplant</b> | 3 1/2 mos. | d. <b>renal failure x 3 days</b> | 3 1/2 mos. | Approximate Interval Between Onset and Death |  |
| {   | a. <b>fulminant sepsis</b>       | 3 days  |  |   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
|   | b. <b>immunosuppression</b>      | 3 weeks   |  |   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
|   | c. <b>liver transplant</b>       | 3 1/2 mos.  |  |   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
|   | d. <b>renal failure x 3 days</b> | 3 1/2 mos.  |  |   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>renal failure x 3 days</b>   |                                  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |                                  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                            |        |                             |         |                            |            |                                  |            |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |                                  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |                                  | 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |                                  |   |  |   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stephen Barnes</i>  |                                  |   |  | 29c. LICENSE NUMBER<br><b>57280</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-11-91</b>                        |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Stephen Barnes, MD 1000 Fell Street #628 Baltimore, MD 21231</b>  |                                  |   |  |   |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>  |                                  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |                            |        |                             |         |                            |            |                                  |            |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3145

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital by attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANBELA STANLEY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>2</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>12:40 P</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-86-2337</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>25</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/23/65</b>                                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, DC</b>   |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>SO. MARYLAND HOSPITAL</b>   |  | 10. CITY, TOWN OR LOCATION OF DEATH<br><b>CLINTON</b>                                       |  |
| 11. RESIDENCE OF DECEDENT<br>10a. STATE <b>MD</b><br>10b. COUNTY <b>Prince George's</b><br>10c. CITY, TOWN OR LOCATION <b>Oxon Hill</b><br>10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>10e. STREET AND NUMBER <b>1022 Marcy Avenue, #103</b><br>10f. ZIP CODE <b>20745</b><br>10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>   |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>+1</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Administrative Ass't</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Helicopter Assoc., Inc.</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas E. Stanley</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jean Thornton</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jean Stanley</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1022 Marcy Avenue, #103, Oxon Hill, Md. 20745</b>                                       |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>  |  | 20c. DATE<br><b>8/08/91</b>   |  | 20d. LOCATION — City or Town, State<br><b>Landover, Md.</b>                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Phillip Bell</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert G. Mason Funeral Home, Inc.<br/>1661 Good Hope Road, S.E., Wash., DC 20020</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>AIDS</b><br>b. <b>Septic</b><br>c. <b>Dehydration</b><br>d. <b>Carditis</b><br>e. <b>Decubital</b><br>f. <b>Anuria</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Arthur M. [Signature]</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D24208</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/2/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ABULHASAN U ANSARI MD</b><br><b>5926 Woodland Rd SE<br/>CLinton Md. 20735</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 11 '91</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAULINE C. SPADY</b>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUG. 14, 1991</b>   |  | 3. TIME OF DEATH<br>M<br><b>5:30 P.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>167-20-5715</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>11-11-24</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>  |  | 9. COUNTY OF DEATH<br><b>WICOMICO</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA GENERAL HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>  |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |
| 10a. STATE<br><b>VIRGINIA</b>  |  | 10b. COUNTY<br><b>NORTHAMPTON</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>TOWNSEND</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>P.O. Box 21</b>   |  | 10f. ZIP CODE<br><b>23443</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>COOK</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>RESTAURANT</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RESTAURANT</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LONDON AMES</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ROSE MORRIS</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOHN H. SPADY</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 21 TOWNSEND, VA. 23443</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>COMMUNITY CEMETERY 8-12-91</b>   |  | 20c. LOCATION — City or Town, State<br><b>CAPE CHARLES, VA.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOHN O. MORRIS FUNERAL HOME<br/>P.O. Box 175 NASSAWADOX, VA. 23413</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Hepatic Insufficiency</b>  |  | Approximate interval Between Onset and Death<br><b>2 months</b>   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. <b>metastatic Carcinoma of Endometrium</b>  |  | <b>18 months</b>  |  |
|  |  | c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |   |  |
|  |  | d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  | 29c. LICENSE NUMBER<br><b>030690</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/14/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James E. Martin M.D. 145 E. Carroll St., Salisbury, MD.</b>  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 20 91</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Joseph Clarence Staup Jr.</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>8-20-91</i>  |  | 3. TIME OF DEATH<br>HOUR MIN<br><i>7:30 A</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>212-16-4821</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>YRS.<br><i>70</i>   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>10-19-1920</i>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>2824 Old Washington Rd.</i>   |  |   |  | 8b. CITY/TOWN OR LOCATION OF DEATH<br><i>Westminster</i>  |  | 8c. COUNTY OF DEATH<br><i>Carroll</i>   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Carroll</i>   |  | 10c. CITY/TOWN OR LOCATION<br><i>Westminster</i>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>2824 Old Washington Rd.</i>   |  |   |  | 10f. ZIP CODE<br><i>21157</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>WW II</i> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br><i>White</i>                                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>10</i> College (13-16 or 17+)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Chief Custodian</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Baltimore County School Bd.</i>                            |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph Clarence Staup Sr.</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Margaret Gertrude Etzler</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Rhoda C. Staup</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2824 Old Washington Rd. Westminster Md 21157</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><i>High U.M. Church Cemetery Westminster Md</i>   |  | 20c. LOCATION — City or Town, State<br><i>Westminster Md</i>                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Rhoda C. Staup</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Fletcher Funeral Home Westminster Md</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Malignant ascities (Adenocarcinoma)</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><i>4 months</i>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>HOURS MIN.   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William R. O'Rourke MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D09389</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>8/22/91</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>William R. O'Rourke W. Main St. Westminster Md. 21157</i>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>AUG 22 '91</i>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MAUDE SARAH SMITH</b><br><i>Maude S. Smith</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 21 91</b>   |  | 3. TIME OF DEATH<br><b>5:45 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-36-3808</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>October 19, 1896</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Washington</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>442 North Prospect Street</b>  |  |
| 10f. ZIP CODE<br><b>21740</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>School Teacher</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Public Schools</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Abraham Lincoln Smith</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rebecca Frances Bonebrake</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary R. Rice</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>440 North Prospect Street, Hagerstown, Md. 21740</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery 8-24-91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Wash., Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. Noel Brady</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Andrew K. Coffman Funeral Home, Inc.<br/>40 East Antietam Street, Hagerstown, Md. 21740</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest</b>  |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |  |
| b. <b>Acute pancreatitis</b>   |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| c. <b>Hypertensive arteriosclerotic cardiovascular disease</b>   |  |  |  |  |  |   |  |
| d. <b>Right hemisphere cerebrovascular accident - old</b>  |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Richard E. Smith, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D10675</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/21/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Richard E. Smith, M.D. 1708 Oak Hill Ave. Hagerstown, Md 21740</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 23 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>MARGIE E. SAUM</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>19</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>5 PM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-09-5261</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>96</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 15, 1895</b>                     |   |
| 8. BIRTHPLACE (State or foreign country)<br><b>Pennsylvania</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                         |   |
| 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  |  |   |
| 10b. COUNTY<br><b>Washington</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  |  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>826 Pope Avenue</b>  |  |  |   |
| 10f. ZIP CODE<br><b>21740</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>       |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary <input type="checkbox"/> Secondary (9-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>laborer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>shoe company</b>                            |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>not available</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nannie Bear</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Irene Irby</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2457 Virginia Ave., Hagerstown, Md. 21740</b>   |  |  |   |
| 20a. MANNER OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery</b>   |  | 20c. DATE<br><b>8/22</b>  |  | 20d. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>               |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott M. Minnich</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL INFARCTION</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>CONGENITAL HEART DISEASE</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ATRIAL FIBRILLATION</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James Physician</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D17067</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/19/91</b>                            |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>STEVEN M. MORGAN, MD 1825 Haven Rd HAGERSTOWN, MD</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 21 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Dorothea V. Smith</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH <i>8</i> DAY <i>21</i> YEAR <i>91</i>   |  | 3. TIME OF DEATH<br><i>0100</i> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>216-14-6306</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>69</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>02/16/1922</i>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Wash. Co. Hospital</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hagerstown</i>  |  | 9c. COUNTY OF DEATH<br><i>Washington</i>  |  |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Washington</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Hagerstown</i>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>11 W. Baltimore St.</i>  |  |   |  | 10f. ZIP CODE<br><i>21740</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>white</i>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11</i><br>College (14 or 5+) <i>0</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>homemaker</i>               |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Vernie Barrow Sr.</i>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Louise Inez Ridenour</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Dorothy Miller</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>13364 Crest Pond Rd., Clear Spring, Md. 21722</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Rest Haven Cemetery</i>                                   |  | DATE<br><i>8/23</i>   |  | 20c. LOCATION — City or Town, State<br><i>Hagerstown, Maryland</i>                              |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott M. Minnick</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>MINNICH FUNERAL HOME</i><br><i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>                            |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio pulmonary arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Probably Pulmonary Embolism</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Chronic renal failure, heart failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>S/P CAPD</i><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>S/P Cholecystectomy</i>  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Bruce Pulivarti, MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D00233</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>8/21/91</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>BAPURAO PULIVARTI, MD 1714 OAK HILL AVE, Hagerstown, MD 21740</i>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>AUG 23 '91</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Tridone Ridenour</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |   |  |   |  |                                   |  |
|--|--|--|---|---|---|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOLORES M. STUART</b>   |  |  |   |   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-26-1991</b>             |   | 3. TIME OF DEATH<br><b>3:10 A. M.</b>  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>465-07-6595</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |   | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-12-1915</b>           |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Minnesota</b>   |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  |  |   |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>           |   | 9c. COUNTY OF DEATH<br><b>Washington</b>   |                                   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  | 10b. COUNTY<br><b>Washington</b>  |   | 10c. CITY, TOWN OR LOCATION<br><b>Boonsboro</b>   |  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |                                   |  |
| 10e. STREET AND NUMBER<br><b>303 Orchard Manor Drive</b>   |  |  |   |   | 10f. ZIP CODE<br><b>21713</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |                                   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1 Yr.</b>  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |   |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Personal Residence</b>        |   |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles</b>  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mauren Christine Schneider</b>  |   |   |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Claudia M. Kiracofe</b>   |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>206 Young Avenue Boonsboro, Maryland 21713</b>  |   |   |  |   |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematorium 8-27-1991</b>  |   |   | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Maryland</b> |   |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Douglas A. Fiery</b>   |  |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br><b>7606 Old National Pike<br/>Bast Funeral Home Boonsboro, Maryland</b> |  |   |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |   |   |   |  |   | Approximate Interval Between Onset and Death   |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |                                   |  |
|  |  |  |   |   |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |  |                                   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
|  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |                                   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |   |  |   |  |                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |  |   |   |   | 29c. LICENSE NUMBER<br><b>D21457</b>                               |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/26/91</b>  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ABDUL WAHEED MD - 1610 OAK HILL AVE. HAGERSTOWN. MD 21740</b>  |  |  |   |   |   |  |   |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 27 '91</b>   |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Juha Davidson-Randall</b>   |   |   |  |   |  |                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

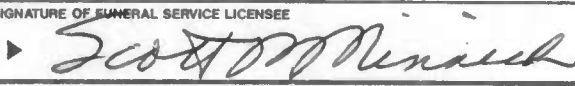

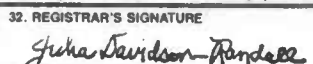
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20-35 97

91 23807

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Phyllis Eleanor SHOOK</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 23, 1991</b>  |  | 3. TIME OF DEATH<br>M<br><b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 17, 1922</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>905 W. Washington St.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>905 W. Washington St.</b>  |  |  |  | 10f. ZIP CODE<br><b>21740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>housewife</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>---</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William N. Seville</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Olive E. Peck</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Gregory P. Shook</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>905 W. Washington St., Hagerstown, Md. 21740</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Memorial Park 8/26 Hagerstown, Maryland</b>              |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA OF THE RECTUM, METASTATIC (STAGE IV)</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>2 YEARS</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CONGESTIVE HEART FAILURE</b><br><b>HYPERTENSION</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |
| 29c. LICENSE NUMBER<br><b>D388 92</b>   |  |  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/23/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PAMELA FOX BRADFORD, MD 1799 HOWELL RD HAGERSTOWN, MD 21740</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 26 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOOTER 12



91 23808

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |   |   |  |  |
|---|--|--|--|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Ida Mae Shields</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>08</i> DAY <i>14</i> YEAR <i>1991</i>  |   | 3. TIME OF DEATH<br><i>0600</i> M   |  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>21-14-1572</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><i>78</i> YRS. |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>NOV. 3, 1912</i> |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>HORNTOWN, VA.</i> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>RIVERVIEW NURSING HOME</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>SALISBURY</i>   |   | 9c. COUNTY OF DEATH<br><i>WICOMICO</i>  |  |  |
| 10a. STATE<br><i>MD.</i>  |  | 10b. COUNTY<br><i>WICOMICO</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>SALISBURY</i>   |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |
| 10e. STREET AND NUMBER<br><i>TIMES SQUARE</i>   |  |  |  | 10f. ZIP CODE<br><i>21801</i>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>BLACK</i>  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>6th</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>DOMESTIC</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>HOUSEWIFE</i>  |   |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>THOMAS WALLOP</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>EMMA HANDY</i>  |   |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>LINWOOD SHIELDS</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>R.D.# 1, BOX 16B, HOUSTON, DE. 19954</i>  |   |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>TABNALE BAPTIST CHURCH CEM.</i>   |  | 20c. LOCATION — City or Town, State<br><i>17 HORNTOWN, VA.</i>  |   |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lorella B. Jolley</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>JOLLEY MEMORIAL CHAPEL, RTE. 2, BOX 920<br/>SALISBURY, MD. 21801</i>   |   |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. <i>Rectal Abscess</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Diverticulosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |   | Approximate Interval Between Onset and Death<br><i>5 days?</i><br><i>3 wks</i><br><i>years</i>  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Left Coronary Vascular Accident, Scurvy disease</i><br><i>History Cerebral aneurysm.</i>   |  |  |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |   |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Thomas C. Hill Jr. M.D. Medical Director</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D 08008</i>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><i>08-14-91</i>  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>THOMAS C. Hill Jr. 108 Pine Bluff Rd. Salisbury, Md. 21801</i>  |  |  |  |   |   |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>AUG 20 '91</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |   |   |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

20-7-12

91 23809

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DAVITA R. THOMPSON</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>16</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>5:30 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-62-9739</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 10, 1905</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Wash., D.C.</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sharon Nursing Home 18201 Marlen Lane</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OLNEY</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>15608 Hackney Lane</b>   |  |   |  | 10f. ZIP CODE<br><b>20906</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Stanley H. Ridings</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jessie Shiflett</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John George Fletcher</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10 Castlewood Dr., Pleasanton, CA 94566</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>8/19 Suitland, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Michael D. Nelson</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph Gawler's Sons, Inc.<br/>5130 Wisconsin Ave, NW, Washington, DC 20016</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Severe Debilitation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Alzheimer's Dementia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>years</b><br><b>years</b> |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 30. SIGNATURE AND TITLE OF CERTIFIER<br><b>James Roum MD</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D37495</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/16/91</b>  |  |
| 31. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James Roum MD - 11910 Ashley Dr, Rockville, MD</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 19 '91</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodette</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HERMAN TUNNE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> - DAY <b>14</b> - YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>1:35 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>279 34 0341</b>  |  | 5. SEX<br><b>XX</b> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>09-17-38</b>   |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>SO. MARYLAND HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CLINTON</b>  |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>P.G.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>HILLCREST HEIGHTS, MD</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><b>XX</b> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>4708 IVERSON PL</b>   |  | 10f. ZIP CODE<br><b>20745</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>MANAGER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RENTAL CO.</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Herman Tunne</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gladys Bradshaw Tunne</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>STELLA V. MACK</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1917 16TH ST. S.E. WASH. D.C. 20020</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>WASHINGTON NATIONAL</b>  |  | 20c. LOCATION — City or Town, State<br><b>SUITLAND, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph E. Williams</i>   |  |  |  | 22. NAME AND ADDRESS OF FUNERAL HOME<br><b>RALPH WILLIAMS FUNERAL SVC.<br/>719 KENNEDY STREET N.W.</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Anal cancer with metastases to the pelvis and urinary bladder</b>  |  |  |  |  |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Keith Y. Yeh</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D14730</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-14-91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kai-Yin YEHUNG, MD, 8826 Woodland Rd #201 Clinton, MD 20725</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TERRANCE GERADE TAYLOR</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 8 1991</b>  |  | 3. TIME OF DEATH<br><b>11:45 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>226-41-4342</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>19 YRS.</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>DEC. 12, 1971</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NIH, THE CLINICAL CENTER</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA, MARYLAND</b>  |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |
| 10a. STATE<br><b>VIRGINIA</b>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>WARRENTON</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>QUARTER 110 VINTHILL STATION</b>   |  |   |  | 10f. ZIP CODE<br><b>22186</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Student</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>College</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES (NMN) TAYLOR</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AGNES (NMN) GREEN</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JAMES TAYLOR</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>QUARTER 110 VINTHILL STA., WARRENTON, VA 22186</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hampton National Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Hampton. VA</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J.P. Marshall</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Marshall's Funeral Home<br/>4217 9th St NW: Washington, DC</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia, Aspergillus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>Glioblastoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>3 weeks</b><br><b>3 years</b> |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Janet Franklin Johnson MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>69274-TX</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>August 9, 1991</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JANET FRANKLIN JOHNSON, M.D. 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 11 '91</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained for the attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the certificate as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Oscar Eugene Tolbert</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>Aug</b> DAY <b>14</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>4:30 P.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>218-05-7199</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 2, 1911</b>                                     |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Harford Memorial Hospital</b>  |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Havre de Grace</b>  |  | 8c. COUNTY OF DEATH<br><b>Harford</b>   |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Cecil</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Conowingo</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>270 Mt. Zoar Road</b>  |  |   |  | 10f. ZIP CODE<br><b>21918</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Tool &amp; Parts Attendant</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>B.R.L. of A.P.G.</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward Tolbert</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Beatrice Berry</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary A. Tolbert</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>270 Mt. Zoar Road, Conowingo, Maryland. 21918</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt Zoar Cemetery</b>  |  | DATE<br><b>8/19</b>   |  | 20c. LOCATION — City or Town, State<br><b>Conowingo, Maryland.</b>                              |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lee A. Patterson &amp; Son Funeral Home</b><br><b>Perryville, Maryland. 21903</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. myocardial infarction.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. S/P right upper lobectomy for sq. cell carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate interval between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>respiratory support on ventilator</b>  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.  |  |   |  | 29c. LICENSE NUMBER<br><b>D14544</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/14/91</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>IAN D. SOMERVILLE 400 LEWIS ST HAVRE DE GRACE MD -21078</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 '91</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |   |   |

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |  |
|--|--|--|--|---|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Semiramis B. Thomas</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 11, 1991</b>  |  | 3. TIME OF DEATH<br><b>2:00 P M</b>  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>162-283256</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>November 19, 1895</b>  |  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Manor Nursing Home</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rising Sun</b>   |  |  |
| 9c. COUNTY OF DEATH<br><b>Cecil County</b>   |  |  |  | 10a. STATE<br><b>Pennsylvania</b>   |  | 10b. COUNTY<br><b>Delaware</b>   |  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Wayne</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>306 North Wayne Avenue</b>  |  |  |
| 10f. ZIP CODE<br><b>19087</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) high school</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>office worker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>UNKNOWN</b>   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Eri Barton</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna McIntire</b>   |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert Thomas</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>523 Newtown Rd., Berwyn, PA 19312</b>   |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SILVERBROOK CREMATORY 8-12-91 WILMINGTON, DE</b>  |  | 20c. LOCATION — City or Town, State  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard L. Goodie</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>R.T. FOARD FUNERAL HOME<br/>RISING SUN, MARYLAND</b>   |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Renal Failure</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Carcinoma of the Kidney</b><br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br> |  |  |  |   |  |  | Approximate Interval Between Onset and Death |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Neil R. Taylor MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>0-11115</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-11-91</b>  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NEIL R. TAYLOR, JR. PO BOX 459, RISING SUN, MD 21911</b>   |  |  |  |   |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson Randall</i>   |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDWARD, THOMAS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>15</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>9:35 P</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-039571</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>03/04/11</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>JOHN HOPKINS Geriatric Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO</b>  |  |
| 9c. COUNTY OF DEATH   |  |  |  |   |  |  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Calvert</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Owings</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>Box 69 Skinners Turn Road</b>  |  |  |  | 10f. ZIP CODE<br><b>20736</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Blk</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0-4</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Brick Layer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Thomas</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Harriet Emerson</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>George Thomas</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Box 110 Skinners Turn Rd., Owings, Md 20736</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Hope Church Cem. 8/20/91</b>                       |  | 20c. LOCATION — City or Town, State<br><b>Sunderland, Md</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Spencer E. Sewell</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1451 Dares Beach Rd.<br/>Sewell Funeral Home Prince Frederick, Md</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ca of head &amp; neck - (Sq Cell)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>COPD</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Fract, malnutrition, urinary retention</b> |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Fract, malnutrition, urinary retention</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>S. R. Heath, MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>P33320</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/16/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Gloth 5505 Bay View Circle Balto., MD 21224</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 20 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gula Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0820

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT T. VIOLETT</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 11, 1991</b>   |  | 3. TIME OF DEATH<br><b>11:45 PM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-34-3263</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 16, 1911</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WASHINGTON, D.C.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>10901 RIVERWOOD DRIVE</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>POTOMAC</b>  |   |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>MT. AIRY</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>13254 PENN SHOP ROAD</b>  |   |
| 10f. ZIP CODE<br><b>21771</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+) <b>5</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ACCOUNTANT</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RANDOLPH T. VIOLETT</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ROSE CASSELL</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY M. VIOLETT (WIFE)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13254 PENN SHOP ROAD MT. AIRY, MARYLAND 21771</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY 8/15</b>   |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James E. Dooly</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia</b>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John G. Lodmell MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>DGS809</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-12-91</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOHN G. LODMELL MD 2901 OLNEY RD OLNEY MD 20832</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 14 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>June Davidson-Randall</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

610-7 10



91 23816

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FRANK WASHE</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8/11 / 91</b>  |  | 3. TIME OF DEATH<br><b>6:39 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>383-09-6045</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/26/18</b>  |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery General Hospital</b>  |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Prince Philip Dr. Olney</b>   |  | 8c. BIRTHPLACE (State or Foreign Country)<br><b>Michigan</b>  |  |
| 9. COUNTY OF DEATH<br><b>Montg.</b>   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Derwood</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>16835 Bethayres Rd.</b>  |  |   |  | 10f. ZIP CODE<br><b>20855</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br><b>6-1-39 to 1-31-65</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Chief Petty Officer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Navy</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Henry Washe</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Catherine Zachary</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Claire Washe</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16835 Bethayres Rd., Derwood, Md. 20855</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arlington National Cem. 8/14</b>  |  | 20c. LOCATION — City or Town, State<br><b>Arlington, VA</b>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>X.E. [Signature]</b>                                |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Drive</b><br><b>Gaithersburg, MD 20877</b>  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ATHEROCLIMOTIC CARDIOVASCULAR DISEASE.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>STATUS POST CEREBROVASCULAR ACCIDENT</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>RIGHT INTERNAL CAROTID ARTERY STENOSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>HYPERTENSION</b><br>Approximate Interval Between Onset and Death<br><b>3 MONTHS</b><br><b>UNDETERMINED</b> |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>STATUS POST RIGHT INTERNAL CAROTID ENDARTHERECTOMY</b><br><b>RENAL FAILURE NOT REQUIRING HEMODIALYSIS.</b><br><b>SEIZURE DISORDER</b>  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>MARIO H. DIAZ M.D.</b>  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/11/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>MARIO H. DIAZ M.D. 1811 PRINCE PHILIP DR. OLNEY MARYLAND.</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 '91</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodell</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


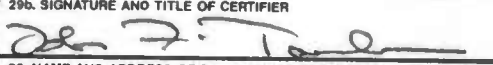
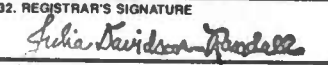
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23817

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Robert W. Wilson Jr.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 15, 1991   |  | 3. TIME OF DEATH<br>1:00 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>578-44-1466   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>59 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>August 1, 1932  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>10135 Dallas Avenue  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Silver Spring  |  | 9c. COUNTY OF DEATH<br>Montgomery   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Silver Spring  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>10135 Dallas Avenue  |  |  |  | 10f. ZIP CODE<br>20901  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)<br>4  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Real Estate Investment  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Real Estate   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert W. Wilson Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Catherine Sheehan  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>John M. Wilson   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>104 Giddings Avenue Severna Park, Maryland 21146   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>August 19, 1991<br>Gate of Heaven Cemetery  |  | 20c. LOCATION — City or Town, State<br>Silver Spring, Maryland  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> M00335   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Robert A. Humphrey Funeral Home/<br>Bethesda-Chevy Chase, Inc. 7557<br>Avenue Bethesda, Maryland 20814 Wisconsin  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrhythmia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Coronary arteriosclerosis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER<br>D08546   |  | 29d. DATE SIGNED (Month, Day, Year)<br>August 15, 1991  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John F. Tauber M.D. 8218 Wisconsin Avenue Bethesda, Maryland 20814  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 19 '91  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

10

ON THE PRESENT OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-01-01

2000-01-01

Whalen, Mary 91 23818

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY CATHERINE WHALEN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 18, 1991</b>  |  | 3. TIME OF DEATH<br><b>7:00 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>053-28-1278</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>AUGUST 7, 1899</b>            |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>IRELAND</b>   |  |  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CARROLL MANOR NURSING HOME</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>HYATTSVILLE</b>   |  | 9c. COUNTY OF DEATH<br><b>PRINCE GEORGE'S</b>                              |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>PRINCE GEORGE'S</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>HYATTSVILLE</b>                          |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>4922 LASALLE ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>20782</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b> |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 8+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do not use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GARRETT DOYLE</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CATHERINE MALONEY</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>REV. JOHN P. WHALEN (SON)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1614 PARHAM ROAD SILVER SPRING, MARYLAND 20903</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. JOSEPH'S CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>TROY, NEW YORK</b>               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute respiratory failure, terminal</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Congestive Heart Failure</i><br><i>Arteriosclerotic Heart Disease</i><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pneumonia, bilateral, recent</i> |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>DO4606</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>18 August 1991</b>               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOHN F. BRENNAN, JR., MD 3415 HAMILTON ST. HYATTSVILLE, MD 20782</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 20 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Margaret Tate Wallace   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Aug. 12, 1991  |  | 3. TIME OF DEATH<br>9:55 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>237-07-4002  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>73 YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 11, 1918  |  | 8. BIRTHPLACE (State or Foreign Country)<br>North Carolina   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>5817 Lenox Road   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Bethesda  |  | 9c. COUNTY OF DEATH<br>Montgomery  |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Bethesda  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>5817 Lenox Road  |  | 10f. ZIP CODE<br>20817   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>if yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Albert A. Tate   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Carrie E. Mc Cord   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Joseph J. Wallace   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5817 Lenox Road, Bethesda, MD 20817   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arlington National Cem. 8/14  |  | 20c. LOCATION — City or Town, State<br>Arlington, VA   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael E. Nelson</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br>Joseph Gawler's Sons, Inc.<br>5130 Wisconsin Ave, NW, Washington, DC 20016   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Shock<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Metastatic cancer<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Cancer ovary<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>Approximate Interval Between Onset and Death<br>1 day<br>5 mos. |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stanley Schwartz</i>  |  | 29c. LICENSE NUMBER<br>D 17368   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Aug. 12, 1991   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Stanley Schwartz, M.D. 5454 Wisconsin Ave., Chevy Chase, MD. 20815   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 14 '91   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |   |  |
|--|--|--|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>THOMAS LEE WINDER  |  |  |  | 2. DATE OF DEATH<br>MONTH: AUGUST DAY: 13, YEAR: 1991   |  |  |   | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-28-2846   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>59 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>8-17-31      |   | 8. BIRTHPLACE (State or Foreign)<br>MARDELA SPRINGS   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>PENINSULA GENERAL HOSPITAL CENTER  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SALISBURY  |  |  |   | 9c. COUNTY OF DEATH<br>WICOMICO   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |   |   |  |
| 10a. STATE<br>MD.  |  | 10b. COUNTY<br>WICOMICO  |  | 10c. CITY, TOWN OR LOCATION<br>MARDELA SPRINGS  |  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>RTE. 1, BOX 288, NORRIS TWILLEY RD.  |  |  |  | 10f. ZIP CODE<br>21837  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                   |   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11th. grade   |  |  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>LABORER  |  | 15b. KIND OF BUSINESS/INDUSTRY<br>DRESSER'S INDUSTRIES |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JAMES WINDER  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>EMMA HEATH   |  |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARY B. WINDER   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>ADDRESS SAME AS ABOVE  |  |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT. ZION UM CHURCH CEMETERY   |  |  | 20c. LOCATION — City or Town, State<br>SHARPTOWN, MD.               |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lorela D. Jolley</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>JOLLEY MEMORIAL CHAPEL, RTE. 2, BOX 920<br>SALISBURY, MD. 21801   |  |  |   |   |  |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>lung cancer</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>deep vein thrombosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |   |  |  |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M                               |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |   |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |   | 29c. LICENSE NUMBER<br>D29349   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>8/16/91   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>W.C. Kellman, M.D., 1104 Medical Center, Rt. 50 E. N. H. St. Salisbury, Md.  |  |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 16 '91  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23821

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><del>Betty Zook</del> <del>Kenneth</del> <del>Walsh</del>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>8 15 1991   |  | 3. TIME OF DEATH<br>3:21 P.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>None  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>N/A 4 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>8/8/19   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Baltimore, Maryland  |  |   |  | 9. COUNTY OF DEATH<br>Baltimore City  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Francis Scott Key Medical Center   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  | 9c. COUNTY OF DEATH<br>Baltimore City   |  |
| 10a. STATE<br>M.D.   |  | 10b. COUNTY<br>Cecil  |  | 10c. CITY, TOWN OR LOCATION<br>ELKTON   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>16 LEEDS RD ELKTON   |  |   |  | 10f. ZIP CODE<br>21921  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input checked="" type="checkbox"/> None<br>College (1-4 or 5+) <input checked="" type="checkbox"/> None  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>None  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>None  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><del>STEVEN</del> <del>WALSH</del> Steven Walsh   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>CHRISTIE Renninger   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>CHRISTIE Renninger   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16 Leeds Rd ELKTON MD 21921  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Union Cemetery 18-91   |  | 20c. LOCATION — City or Town, State<br>Elkton, Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert T. Crouch</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Crouch Funeral Home<br>127 South Main St. North East, Maryland  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → MULTIPLE CONGENITAL ANOMALIES<br>a. TETRALOGY OF FALLOT<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. TE FISTULA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. RESPIRATORY FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. CLEFT LIP AND PALATE<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)<br>8/15/91  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Homa Mknaf MD   |  |   |  | 29c. LICENSE NUMBER<br>D37630   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/15/91  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Homa Mknaf FRANCIS SCOTT KEY MEDICAL CENTER.  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 19 91   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23822

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Annie R. Washington</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 21, 1991</b>  |  | 3. TIME OF DEATH<br><b>1553 p M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-64-4054</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 15, 1909</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Prince Frederick</b>  |  | 9c. COUNTY OF DEATH<br><b>Calvert</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Calvert</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>St. Leonard</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>6780 Mackall Road</b>   |  |  |  | 10f. ZIP CODE<br><b>20685</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0-4</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Domestic</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas B. Rawlings</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Della Parker</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carolyn Gray</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5425 Broomes Island Rd., Port Republic, Md 20676</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Brooks Church Cemetery 8/26/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>St. Leonard, Md</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Spencer E. Sewell</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1451 Dares Beach Rd.<br/>Sewell Funeral Home Prince Frederick, Md</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Poss acute mi. - sudden death</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. CAD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Chronic Brain Syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kiourmarce Yazdani</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>MD 17168</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/21/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Kiourmarce yazdani Huntingtown, Md.</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 26 1991</b>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21115-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the certificate as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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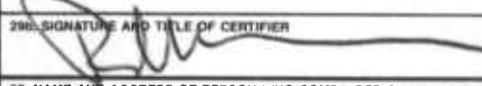
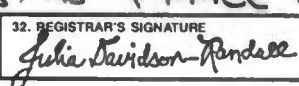
10-10-88

91 23823

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen Elizabeth WEAVER</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 20, 1991</b>  |  | 3. TIME OF DEATH<br>M<br><b>22:05</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220 09 5140</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12/01/1912</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, D.C.</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Prince Frederick</b>  |  | 9c. COUNTY OF DEATH<br><b>Calvert</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Calvert</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>North Beach</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>4032 3rd Street</b>   |  |  |  | 10f. ZIP CODE<br><b>20714</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                            |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sales Clerk</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Retail Dept. Store</b>   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Hebert H. Hetterly</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ethel M. Thompson</b>   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Clarence J. Weaver</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as # 10 above</b>  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery 8/23/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Cheltenham (PG) MD</b>  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rausch Funeral Home, Owings, MD 20736</b>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>breast cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  | Approximate interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> VERIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D22615</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/21/91</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ronald J. Ross MD Prince Frederick MD 20678</b>  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 23 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the cause of death be certified by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23824

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EARL Sherman WALKER</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 14, 1991</b>  |  | 3. TIME OF DEATH<br><b>2329 p M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214 28 4167</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-13-1930</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CALVERT MEMORIAL HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>PRINCE FREDERICK</b>  |  | 9c. COUNTY OF DEATH<br><b>CALVERT</b>   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Calvert</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>11207 Maplewood Drive DUNKIRK</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>11207 Maplewood Drive</b>   |  |   |  | 10f. ZIP CODE<br><b>20754</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1950's</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>61</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Self-employed</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Liquor Store- retail</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Lee Walker</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gertrude Brady</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Earl Gregory Walker</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13534 Lord Sterling Place, Upper Marlboro, MD 20772</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Carmel Cem. 8-19-91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Upper Marlboro (PG) MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rausch Funeral Home, Owings, MD 20736</b>  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Chronic arteriosclerotic</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Cardiovascular disease.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Hypertension.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>R. sided myocardial infarction</b> |  |   |  |   |  |   | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br><b>D 12705</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/15/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Emad Al-Banna, M.D. Prince Frederick, Maryland</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KATIE WINGERED YODER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUG. 20, 1991</b>   |  | 3. TIME OF DEATH<br><b>7:20 A.M. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>NONE</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 17, 1907</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>AT HOME, 912 DIXIE LYON RD.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>MECHANICSVILLE</b>   |  |
| 9c. COUNTY OF DEATH<br><b>ST. MARY'S COUNTY</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>ST. MARY'S COUNTY</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>MECHANICSVILLE</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>912 DIXIE LYON ROAD</b>   |  |
| 10f. ZIP CODE<br><b>20659</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH. GRADE</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GIDEON M. WINGERED</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SALOMA K. BYLER</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JONAS B. YODER</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5869 BUENA VISTA RD, GAP, PA. 17527</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HERTZLER CEMETERY</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>MECHANICSVILLE, MD.</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael K. Lindner</i>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>MATTINGLEY-GARDINER FUNERAL HOME, P.A.<br/>P.O. BOX 270, LEONARDTOWN, MD 20659</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>cardio Resp failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Breast tumor with Metastasis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Card Arrhythmia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>B. J. White</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D33470</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/20/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BHASKER JHAVERI, M.D. SHANTI MEDICAL CENTER, LEONARDTOWN, MARYLAND 20650</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 20 91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Gabe Davidson-Randell</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edward Hylon Young</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 13 1991</b>   |  | 3. TIME OF DEATH<br><b>5:00 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-34-9300</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>51</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan 27, 1940</b>                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>D.C.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>2316 Michigan Avenue</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>                      |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>2316 Michigan Ave,</b>                              |  |
| 10f. ZIP CODE<br><b>20910</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>       |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12 th Grade</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Unemployed</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>None</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward P. Young</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Banks</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print) (Mother)<br><b>Mrs Marie B. Young</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2316 Michigan Ave, Silver Spring, Md 20910</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Md National Park</b>   |  | DATE<br><b>5/17</b>   |  | 20c. LOCATION — City or Town, State<br><b>Laurel, Md</b>                         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George R. Brunden</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SNOWDEN FUNERAL HOME P.A. 20850</b><br><b>246 N. Washington St, Rockville, Md</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Arteriosclerotic Cardiovascular Disease</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Alcoholism</b><br><b>CHRONIC ALCOHOLISM</b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward Hylon Young MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08 14 1991</b>                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Edward Hylon Young MD</b> <b>111 Penn Street, Baltimore Maryland 21201</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 16 '91</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health. **IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |
|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Alice Nellie Yocum   |  |  |  | 2. DATE OF DEATH<br>MONTH 8 DAY 11 YEAR 91   |  |
| 3. TIME OF DEATH<br>10 06 P.M.   |  | 4. SOCIAL SECURITY NUMBER<br>218-34-5817   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  |
| 6. AGE (In yrs. last birthday)<br>78 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>01/09/13  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Mt. Rainier, MD  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Leland Memorial Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Riverdale   |  | 9c. COUNTY OF DEATH<br>Prince George   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Prince George   |  | 10c. CITY, TOWN OR LOCATION<br>Hyattsville   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>5824 33rd Place  |  | 10f. ZIP CODE<br>20782   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>20782   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+) None  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  | 17. FATHER'S NAME (First, Middle, Last)<br>Frank Fauth   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Theresa Emerson   |  | 19a. INFORMANT'S NAME (Type/Print)<br>Marie B. Simpson   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3800 Powell Lane, Falls Church, Virginia 22041  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Lincoln Cemetery 8/15/91  |  | 20c. LOCATION — City or Town, State<br>Brentwood, Maryland   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>[Signature]   |  | 22. NAME AND ADDRESS OF FACILITY<br>Francis Gasch's Sons Funeral Home, PA<br>4739 Baltimore Ave., Hyattsville, MD 20781  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE/CAUSE (Final disease or condition resulting in death) →<br>a. Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Arteriosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br>minutes<br>years |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |
| 28a. DATE OF INJURY (Month, Day, Year)<br>N/A  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature] Deputy Medical Examiner   |  | 29c. LICENSE NUMBER<br>D01852  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>8-12-91   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>PAUL A DEVERE MD 4203 Queenbury Rd Hyattsville MD 20781   |  | 31. DATE FILED (Month, Day, Year)<br>AUG 16 91   |  |
| 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |  |  |

TYPE - 10





PHYLLIS, YATES

91 23828

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Phyllis Ross Elliott Yates</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>7:33</b> <b>A</b> <b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-42-0965</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2/22/1908</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>SALISBURY NURSING HOME</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY, MD.</b>   |  |
| 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Wicomico</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>209 Park Heights Avenue</b>   |  |
| 10f. ZIP CODE<br><b>21801</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Education</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Milburn E. Elliott</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elsie Ross Elliott</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Susan Mach</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1130 Via Salerno, Winter Park, FL 32789</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Trinity Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>8/16 Church Creek, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald P. Brummett</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bounds F.H. 705 E Main ST, Salisbury</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lymphoma</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Colon Cancer</b>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD  |  |  |  | 29c. LICENSE NUMBER<br><b>040170</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/15/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Eddie V. Hines, MD, Salisbury, Wicomico, Salisbury, MD</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 15 '91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23829

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Robert Thompson Zimmerman</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>AUGUST 12 91   |  | 3. TIME OF DEATH<br>6:17 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>210-14-1741  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (in yrs. last birthday)<br>80 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>AUG. 31, 1910   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>PENNSYLVANIA  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>HOLY CROSS HOSPITAL  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>SILVER SPRING   |  |
| 9c. COUNTY OF DEATH<br>MONTGOMERY   |  |  |  | 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>MONTGOMERY  |  |
| 10c. CITY, TOWN OR LOCATION<br>SILVER SPRING  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>15416 BRAMBLEWOOD DRIVE  |  |
| 10f. ZIP CODE<br>20906  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>6   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>ADMINISTRATOR  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>MONTGOMERY CTY SCHOOLS   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>ROBERT LYNNE ZIMMERMAN   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MILDRED A. McCONNELL  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>AILEEN M. ZIMMERMAN (WIFE)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>15416 BRAMBLEWOOD DRIVE SILVER SPRING, MARYLAND 20906   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MEADOWRIDGE MEMORIAL PARK 8/15  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James E. Dooly</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>FRANCIS J. COLLINS FUNERAL HOME, INC.<br>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Coronary artery insufficiency</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Coronary artery disease - Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Arteriosclerotic Heart Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>d.<br>Approximate Interval Between Onset and Death<br>18 days<br>6 years<br>16 years |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Diabetes mellitus</i>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Aaron H. Traum MD</i>   |  |  |  | 29c. LICENSE NUMBER<br>D 12461   |  | 29d. DATE SIGNED (Month, Day, Year)<br>August 12, 1991   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>AARON H. TRAUM MD 8915 GEORGIA AVENUE SILVER SPRING, MD. 20910   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 14 '91   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05000 10

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | CERTIFICATE OF DEATH  |  |                                   |  | REG. NO.  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|--|--|---|--|-----------------------------------|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARION ELIZABETH ZELDER</b>   |  |  |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>09</b> YEAR <b>1991</b>  |  |                                   |  | 3. TIME OF DEATH<br><b>3:25P</b> M  |  |   |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>185-12-2959</b>  |  |  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.    |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 1, 1922</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b> |  |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Doctors Hospital</b>  |  |  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Lanham</b>  |  |                                   |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>   |  |   |  |  |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Prince George's</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Lanham</b>  |  |                                   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |   |  |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>6424 Brightlea Drive</b>  |  |  |  |  |  |  |  | 10f. ZIP CODE<br><b>20706</b>   |  |                                   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |  |  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>NO</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>NO</b> |  |                                   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>caucasian</b>                           |  |   |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th</b>  |  |  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>service representative</b>   |  |  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Hospital</b>   |  |                                   |  |   |  |   |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>unavailable</b>  |  |  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>unavailable</b>   |  |                                   |  |   |  |   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Raymond C. Zelder</b>   |  |  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6424 Brightlea Drive, Lanham, Maryland 20706</b>  |  |                                   |  |   |  |   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery 08-13-91</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Maryland</b>   |  |                                   |  |   |  |   |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Mark A. Brobaum</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A.<br/>4739 BALT. AVE., HYATTSVILLE, MD. 20781</b>   |  |  |  |   |  |                                   |  |   |  |   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic Carcinoma of Ovary</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d.</b> |  |  |  |  |  |  |  |   |  |                                   |  | Approximate Interval Between Onset and Death<br><b>30 days</b>  |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Buodenal ulcers</b><br><b>Diabetes Mellitus</b>   |  |  |  |  |  |  |  |   |  |                                   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |                                   |  |   |  |   |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M                         |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED |  |   |  |   |  |  |  |  |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |                                   |  |   |  |   |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |   |  |                                   |  |   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Thomas J. Maloney MD</i>   |  |  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>DO 7479</b>   |  |                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Aug 9, 1991</b>   |  |   |  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)   |  |  |  |  |  |  |  |   |  |                                   |  |   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 11 '91</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |   |  |                                   |  |   |  |   |  |  |  |  |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Mary Christine ZEHR</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>August 25, 1991</i>  |  | 3. TIME OF DEATH<br>M<br><i>M</i>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>120-36-7027</i>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>88</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>August 25, 1903</i>                            |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Washington County Hospital</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hagerstown</i>  |  | 9c. COUNTY OF DEATH<br><i>Washington</i>   |   |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Washington</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Hagerstown</i>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><i>116 Windsor Drive</i>  |  |  |  | 10f. ZIP CODE<br><i>21740</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>white</i>               |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>housewife</i>                |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>August H. Klunder</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Katherine Nann</i>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Edward G. Zehr</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>116 Windsor Dr., Hagerstown, Md. 21740</i>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Greenlawn Memorial Park</i>                                |  | DATE<br><i>8/28</i>   |  | 20c. LOCATION — City or Town, State<br><i>Williamsport, Maryland</i>                     |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott M. Minnich</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>MINNICH FUNERAL HOME</i><br><i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Carcinoma</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pneumonia</i>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |   |
|   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |   |
|   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. J. Davidson-Randall</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D21457</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>8/25/91</i>                                    |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>ABDUL WATERS, MD - 1610- Oak Hill Ave. HAGERSTOWN - MD 21740</i>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>AUG 26 '91</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>IDA AUERBACH</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 29 91</b>  |  | 3. TIME OF DEATH<br><b>7 45 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579 44 7095</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-15-08</b>   |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>SUBURBAN HOSPITAL</b>   |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA</b>   |  | 10. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |
| 11. STATE<br><b>Maryland</b>  |  | 12. COUNTY<br><b>Montgomery</b>  |  | 13. CITY, TOWN OR LOCATION<br><b>Rockville</b>  |  | 14. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 15. STREET AND NUMBER<br><b>10500 Rockville Pike</b>  |  |  |  | 16. ZIP CODE<br><b>20852</b>  |  | 17. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |
| 18. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 21. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 22. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>8 years</b>   |  | 23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Merchant</b>   |  | 24. KIND OF BUSINESS/INDUSTRY<br><b>Grocery</b>   |  |   |  |
| 25. FATHER'S NAME (First, Middle, Last)<br><b>Meyer Cohen</b>   |  |  |  | 26. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lena (unascertainable)</b>  |  |   |  |
| 27. INFORMANT'S NAME (Type/Print)<br><b>David Auerbach</b>  |  |  |  | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10500 Rockville Pike, Rockville, Maryland 20852</b>  |  |   |  |
| 29. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 30. PLACE AND DATE OF DISPOSITION (Specify cemetery, crematory or other place)<br><b>Sholem Talmud Torah 8/30/1991 Washington, D. C.</b>   |  | 31. LOCATION — City or Town, State  |  |   |  |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stottmeyer</b>  |  |  |  | 33. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME, Inc.<br/>232 CARROLL STREET, N.W., WASHINGTON, D.C.</b>  |  |   |  |
| 34. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>PNEUMONIA WITH SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>CHRONIC LYMPHOCLYTIC LEUKEMIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>BREAST CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Approximate Interval Between Onset and Death |  |  |  |   |  |   |  |
| 35. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____  |  |  |  |   |  |   |  |
| 36. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 37. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 38. 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 39. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 40. 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 41. 28a. DATE OF INJURY (Month, Day, Year)   |  | 42. 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 43. 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 44. 28d. DESCRIBE HOW INJURY OCCURRED   |  | 45. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 46. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 47. 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 48. 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Alpana Goswami M.D.</b>   |  |  |  | 49. 29c. LICENSE NUMBER<br><b>D-27660</b>   |  | 50. 29d. DATE SIGNED (Month, Day, Year)<br><b>8/29/91</b>   |  |
| 51. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ALPANA GOSWAMI 8401 COLESVILLE ROAD SILVER SPRING, MD</b>   |  |  |  |   |  |   |  |
| 52. 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 53. 32. REGISTRAR'S SIGNATURE<br><b>J. A. [Signature]</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the certificate as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEMS:23 thru 28f per ME 91-174  
G-679 9/20/91 cm

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1 - STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Kevin R. Alexander</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 25 1991</b>   |  | 3. TIME OF DEATH<br><b>3:12 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>31</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-1-60</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Baltimore County General</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Randallstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6803 Southern Cross Court</b>   |  |   |  | 10f. ZIP CODE<br><b>21207</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrician</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Alexander Electric</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Haywood Alexander</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anita Lokeman</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Haywood Alexander</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6803 Southern Cross Ct. Balto., MD. 21207</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Western Star Cem. 8-31-91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Balto., MD.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Doretha Hector</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. Phillips F/H 1721-27 N. Monroe St. Balto., MD. 21217</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>NARCOTIC INTOXICATION</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Pending Investigation<br>3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input checked="" type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8/25/91</b>  |  | 28b. TIME OF INJURY<br><b>2:23a M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT USED DRUGS</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND: HOUSE</b>   |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>6912 LIBERTY RD BALTO., MD</b>   |  |   |  |   |  |
| 29a. CERTIFIER (Check only)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. Laron Locke MD</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08 25 1991</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. Laron Locke, MD 111 Penn Street, Baltimore Maryland 21201</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

201-1-12



91 23834

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN K. BATHURST</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>1991</b>  |  | 3. TIME OF DEATH<br><b>4:40 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>129-07-9163</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.   |  | 7. DATE OF BIRTH<br>MONTH <b>1</b> DAY <b>12</b> YEAR <b>1919</b>   |  |
| 8. BIRTHPLACE (State or Foreign)<br><b>PENNSYLVANIA</b>  |  |   |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 10. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |
| 11. FACILITY NAME (If not Institution, give street and number)<br><b>HARBOR HOSPITAL</b>   |  |   |  | 12. CITY, TOWN OR LOCATION<br><b>DUNDALK</b>   |  | 13. INSIDE CITY LIMITS<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                           |  |
| 14. STATE<br><b>MARYLAND</b>   |  | 15. COUNTY<br><b>BALTIMORE</b>  |  | 16. CITY, TOWN OR LOCATION<br><b>DUNDALK</b>   |  | 17. INSIDE CITY LIMITS<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                           |  |
| 18. STREET AND NUMBER<br><b>1900 HOLBORN ROAD</b>  |  |   |  | 19. ZIP CODE<br><b>21222</b>   |  | 20. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 21. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 22. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 23. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 24. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 25. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary (0-12) <b>8 YEARS</b> College (14 or 5+) <b>N/A</b>  |  |   |  | 26. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired)<br><b>COIL DATA RECORDER</b>  |  | 27. KIND OF BUSINESS/INDUSTRY<br><b>BETHLEHEM STEEL CORP.</b>   |  |
| 28. FATHER'S NAME (First, Middle, Last)<br><b>JOHN KOTELNICKI</b>  |  |   |  | 29. MOTHER'S NAME (First, Middle, Last)<br><b>ANNA FAPREN</b>  |  |   |  |
| 30. INFORMANT'S NAME (Type/Print)<br><b>EUGENE BATHURST</b>  |  |   |  | 31. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7727 CHARLESMONT ROAD BALTIMORE, MARYLAND 21222</b>   |  |   |  |
| 32. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 33. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HILLTOP SERVICE CORP 8-31-1991</b>                         |  | 34. LOCATION — City or Town, State<br><b>TOWSON, MARYLAND</b>  |  | 35. NAME AND ADDRESS OF FACILITY<br><b>DUDA-RUCK FUNERAL HOME OF DUNDALK INC.<br/>7922 WISE AVENUE DUNDALK MD 21222</b> |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic Small Lung cell Cancer</b>  |  |   |  |  |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |  |  |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                             |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28e. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Esteban J. Diaz-Mirva MD</b>   |  |   |  |
| 29c. LICENSE NUMBER<br><b>HHC</b>  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/99</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Harbor Hospital Center</b>   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodriguez</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21200

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12 13083



13 13083

91 23835

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Lida Bowen</b>   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-24-2515</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>3 20 13</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  | 9. COUNTY OF DEATH<br><b>Balto.</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Pickersgill Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  | 9c. COUNTY OF DEATH<br><b>Balto.</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Balto.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>615 Chestnut Ave.</b>  |  | 10f. ZIP CODE<br><b>21204</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b>  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Opera Singer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N.B.C. Radio</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Edmund A. Bowen, Sr.</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Miriam C. Davis</b>  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Pickersgill Home</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10e</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery 9/3/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Balto. Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1050 York Rd. 21204<br/>Ruck Towson Funeral Home, Inc.</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Cardiac arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Congestive heart failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>aortic stenosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>NA</b>   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>NA</b>   |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W.A. Riley, M.D.</b>  |  | 29c. LICENSE NUMBER<br><b>025205</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>8/31/91</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>W.A. Riley, M.D. G.BMC 6701 N. Charles Street</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

19 10 1900

19 10 1900



ITEMS: 9a, 28d per ME  
G-680 10/22/91 cm

91 23836

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THEODORE BUSHROD Jr.</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 29 1991</b>   |  | 3. TIME OF DEATH<br><b>08:59 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-90-2258</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>33</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2-8-1958</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Md</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>STREET-WALBROOK &amp; POPULAR GROVE</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3118 Piedmont Avenue</b>  |  |   |  | 10f. ZIP CODE<br><b>21216</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Theodore Bushrod, Sr</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elmira Clark</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elmira Bushrod</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3118 Piedmont Avenue Baltimore, Md 21216</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>9491 Randallstown, Md</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Elmira March</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F/H West<br/>4300 Wabash Avenue</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE GUNSHOT WOUNDS</b>   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <b>PUBLIC STREET</b> |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>08 29 1991</b>  |  | 28b. TIME OF INJURY<br><b>10:50 A</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>PUBLIC STREET</b>  |  | 28e. DESCRIBE NOW INJURY OCCURRED<br><b>SUBJECT SHOT BY POLICE</b>  |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>BALTIMORE CITY</b>   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Donna DeHull</i> per.  |  |   |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08 29 1991</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>UDRAGONA A. KOSOV 111 PENN STREET BALTIMORE, MARYLAND 21201</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Burton</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>John Bollack</i>  |  |  | 2. DATE OF DEATH<br>MONTH <i>8</i> DAY <i>31</i> YEAR <i>91</i>   |   | 3. TIME OF DEATH<br><i>6:23 PM</i>  |
| 4. SOCIAL SECURITY NUMBER<br><i>219-07-1983</i>  | 6. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 8. AGE (In yrs. last birthday)<br><i>78</i> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><i>8/14/1913</i>   |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>Md.</i>  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><i>Key Medical Center</i>  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>   |   | 9c. COUNTY OF DEATH   |
| 10a. STATE<br><i>Md.</i>   |  |  | 10b. COUNTY<br><i>Baltimore</i>   |   | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  | 10e. STREET AND NUMBER<br><i>411 Cornwall Street</i>  |   |   |
| 10f. ZIP CODE<br><i>21224</i>  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>3</i> College (1-4 or 6+) <i>Machine Operator</i>  |   |   |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Truck Body Mgr.</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Adam Bollack</i>   |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Bertha</i>  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Marie M. Moran</i>  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>411 S. Robinson St. Balto., Md. 21224</i> |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Sacred Heart of Jesus Cem.</i>  |   | 20c. LOCATION — City or Town, State<br><i>Dundalk, Md.</i>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles D. Zeiler</i>  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</i>   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Graue Sepsis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><i>Immunocompromize</i><br><i>Wegeners disease with Renal failure</i> |  |  |   |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>HTN</i><br><i>Complete heart block requiring Pacemaker</i>  |  |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |   |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY<br><i>M</i>   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Timothy Kamp (Timothy Kamp MD)</i>   |  |  | 29c. LICENSE NUMBER<br><i>F0002</i>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/1/91</i>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><i>H. Vossbeck, MD / FSKMCH / 4940 Eastern Ave / Baltimore MD 21224</i>  |  |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 3 1991</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>   |   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>George H. Bertling</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>0730 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-03-8119</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/8/14</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |   |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Greater Laurel Beltsville Hosp</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Beltsville</b>   |  | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Howard</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Elkridge</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6274 Montgomery Rd.</b>   |  |   |  | 10f. ZIP CODE<br><b>21227</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b><br>College (1-4 or 5+) <b>College</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>chauffeur</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>retired</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Herman Bertling</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Garner</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mollie L. Bertling</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6274 Montgomery Rd. Elkridge, Md. 21227</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Elkridge, Md. 21227</b>                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Gary L. Kaufman F. H.<br/>5695 Main St., Elkridge, Md. 21227</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |   |  |  |  |   |  |
| a. <b>Pneumonia</b> 16 days  |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |
| b. <del>Congestive heart failure</del> 3 years   |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |
| c. <b>Chronic pulmonary Fibrosis</b> 3 years   |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |
| d. <b>Alzheimer's disease</b> 5 years  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 7 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO               |  |
| 28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Timothy McClain MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D39532</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Timothy McClain, MD 321 Prince George St. Laurel MD 20707</b>  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP/30/1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23839

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HELEN LOUISE BRADBERRY  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>AUGUST 31 1991   |  | 3. TIME OF DEATH<br>8:12 P. M  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-40-4600  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>92 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>DEC. 10, 1898   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>ST. AGNES HOSPITAL   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY  |  |
| 9c. COUNTY OF DEATH<br>---  |  |  |  | 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>BALTIMORE   |  |
| 10c. CITY, TOWN OR LOCATION<br>CATONSVILLE  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>104 OAKDALE AVE.   |  |
| 10f. ZIP CODE<br>21228  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 2+   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>SECRETARY  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>PRIVATE CORPORATION  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>CHARLES R. HASLUP  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ANNA M. LAIRD   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>CHARLES H. BRADBERRY (SON)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>104 OAKDALE AVENUE CATONSVILLE, MARYLAND 21228  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT. HOLLY SPRINGS CEMETERY 9/4/91   |  | 20c. LOCATION — City or Town, State<br>MT. HOLLY SPRINGS PA.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Russell C. Witzke</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES<br>1630 EDMONDSON AVE<br>CATONSVILLE, MD. 21228   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Coronary Artery Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Arteriosclerotic Cardiovascular Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>Old age</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Type II Diabetes Mellitus</i><br><i>COPD</i>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Emergency Room</i>  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>D. Ly</i>   |  |  |  | 29c. LICENSE NUMBER<br>D18429  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-1-91  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Allan Perez M.D., 1009 Enderick Rd., Catonsville, MD 21228   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |   |   |  |
|---|--|---|--|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM B. BOONE JR.</b>   |  |   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>27</b> YEAR <b>91</b>              |   | 3. TIME OF DEATH<br><b>4:50 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 16 1477</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08/28/1920</b>                      |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Balto. Md.</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>                          |   | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |
| RESIDENCE OF DECEDENT   |  |   |  |  |  |   |   |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>HARFORD</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>FALLSTON</b>   |  |   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>3224 CANTERBURY LANE</b>   |  |   |  |  |  | 10f. ZIP CODE<br><b>21047</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W.W. II 1943-46</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b><br>College (1-4 or 5+) <b>4 yrs.</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Supervisor of accounting</b>  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>State of Md.</b>                   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William B. Boone Sr.</b>  |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marguerite Conroy</b> |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Carita E. Boone</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3224 Canterbury Lane, Fallston, Md. 21047</b>  |  |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Pk. 8/30/91</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>Parkville, Md.</b>                  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>E. F. Lassahn</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.F. Lassahn Funeral Home<br/>11750 Belair Rd. Kingsville, Md. 21087</b>  |  |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>METASTATIC LUNG CA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>NOT KNOWN</b> |  |   |  |  |  |   |   | Approximate Interval Between Onset and Death<br><b>2 DAYS</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |  |  |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide<br><input type="checkbox"/> Could not be determined |  |   |   |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED   |   |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D25488</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/27/91</b>                         |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |  |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0060

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

|  |  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PHILLIP K. BALL</b>   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 29 91</b>  |  | 3. TIME OF DEATH<br><b>1:37 A M</b>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>229-40-7266</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F<br><b>M</b>   |  | 8. AGE (In yrs. last birthday)<br><b>55</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>11-11-35</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>11-11-35</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>WASHINGTON ADVENTIST HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TAKOMA PARK, MD.</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGES</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>CHILLUM</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br><b>YES</b> |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>817 FAIROAK AVENUE</b>  |  |  |  | 10f. ZIP CODE<br><b>20783</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                                    |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |   |  |   |  |
| Elementary/Secondary (0-12)<br><b>12 Yrs</b>   |  | College (1-4 or 5+)<br><b>None</b>   |  | <b>Machinist</b>  |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert Ball</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Roxie Campbell</b>  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Leila Ball (Wife)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10a,b,c,d,e,&amp;f</b>  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>Ft Lincoln</b>   |  | DATE<br><b>9/3/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Md</b>   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Juan Smid</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John T Rhines Co., Inc.<br/>3015 12th St NE, DC 20017</b>  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>METASTATIC ADENOCARCINOMA TO LUNGS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>ADENOCARCINOMA 1° SITE UNKNOWN</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>2 years</b><br><b>2+ years</b>                         |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><br>_____  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA             |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                              |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |  |
| 29a. CERTIFIER<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D29294</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/29/91</b>   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>10810 Connecticut Avenue Kensington MD 20895</b>   |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>8/19/91</b>  |  |  |  |   |  |   |  |   |  |   |  |

DMMH-16 Rev 1/89

**DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020**

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAUL T COPPINGER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8 - 31 - 91</b>  |  | 3. TIME OF DEATH<br><b>6:39 A. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-38-7541</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>50</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/24/40</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>  |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |
| 9b. FACILITY NAME (If not institution, give street and number)<br><b>ST JOSEPH HOSPITAL</b>   |  |  |  | RESIDENCE OF DECEDENT   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1607 Sherwood Ave.</b>   |  |  |  | 10f. ZIP CODE<br><b>21239</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Accountant/ Auditor</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Civil Service</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John J. Coppinger</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth C. Russo</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles E. Stogowski, Jr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1607 Sherwood Ave., Balto., Md. 21239</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Cemetery 9-3-91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Balto., Md.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Roy H. Cather</b><br><i>Roy H. Cather</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Pneumocystis pneumonia</b><br><b>AIDS</b> |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Samuel H. Hestrick MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D28625</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-31-91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filing within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DAVID COLKLEY</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>28</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>5:20</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-62-7230</b>   |  | 5. SEX<br><b>1</b> M <b>2</b> F   |  | 6. AGE (In yrs. last birthday)<br><b>37</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-17-53</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Don Secours Hosp</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO MD</b>   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO  |  |
| 10e. STREET AND NUMBER<br><b>2960 Mosher Street</b>   |  |   |  | 10f. ZIP CODE<br><b>21214</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |
| 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                 |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)  |  |   |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 18b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Colkley</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bernice Lamb</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sarah Parker</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 Spice Court Balt, Md 21207</b>                 |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Western Star Cem</b> |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Md</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gola March</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. West<br/>4300 Wabash Ave</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. CARDIAC STANDSTILL</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. BLEEDING DIAPHRAGM</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. CHILD C LIVER DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>6-8 HRS</b><br><b>6-8 HR</b>                         |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>D. W. [Signature]</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D34055</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/28/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DAVID C. NASRACCA - 2000 W. BALTO ST 21225</b>  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2013-2014



91 23844

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RACHAEL STEELE DORSEY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>28</b> YEAR <b>1991</b>  |  | 3. TIME OF DEATH<br><b>6:45P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-09-7322</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/31/1904</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>   |  |   |  |
| 10. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 11. FACILITY NAME (If not institution, give street and number)<br><b>G.B.M.C., 6701 N. CHARLES STREET</b>   |  |   |  |
| 12a. STATE<br><b>MARYLAND</b>  |  | 12b. COUNTY<br><b>BALTIMORE</b>  |  | 12c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  | 12d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 13a. STREET AND NUMBER<br><b>3925 KESWICK ROAD</b>   |  |  |  | 13b. ZIP CODE<br><b>21211</b>   |  | 13c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 14. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 15. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 16. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 17. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
| 18. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  | 19a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 19b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |  |
| 20. FATHER'S NAME (First, Middle, Last)<br><b>JOHN MURRAY STEELE</b>   |  |  |  | 21. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>GERTRUDE W. BROOKS</b>  |  |   |  |
| 22. INFORMANT'S NAME (Type/Print)<br><b>WILLIAM H. DORSEY JR.</b>  |  |  |  | 23. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3925 KESWICK ROAD BALTIMORE, MD. 21211</b>   |  |   |  |
| 24. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 25. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. ANNE'S EPIS. CH. CEM. 8/31</b>  |  | 26. DATE<br><b>8/31</b>   |  | 27. LOCATION — City or Town, State<br><b>ANNAPOLIS, MD. 21401</b>                               |  |
| 28. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. G. Lutz</b>   |  |  |  | 29. NAME AND ADDRESS OF FACILITY<br><b>4905 YORK ROAD 21212<br/>HENRY W. JENKINS AND SONS. BALTO. MD.</b>   |  |   |  |
| 30. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>{ <b>A.S.C.V.D., DEMENTIA, C.H.F.</b> |  |  |  |   |  |   |  |
| 31. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>A.S.C.V.D., DEMENTIA, C.H.F.</b>  |  |  |  |   |  |   |  |
| 32. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 33. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 34. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 35a. DATE OF INJURY (Month, Day, Year)<br><b>8/28/91</b>   |  | 35b. TIME OF INJURY<br><b>M</b>   |  | 35c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 35d. DESCRIBE HOW INJURY OCCURRED  |  | 36a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 36b. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 37. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 38. SIGNATURE AND TITLE OF CERTIFIER<br><b>David G. Roberts M.D.</b>   |  |  |  | 39. LICENSE NUMBER<br><b>D34988</b>   |  | 40. DATE SIGNED (Month, Day, Year)<br><b>8/28/91</b>  |  |
| 41. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David G. Roberts MD 6565 N. Charles St. Suite 405, 21204</b>   |  |  |  |   |  |   |  |
| 42. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 43. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: A death certificate is required to be filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23845

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Barfield, Carlotta T. Barfield</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>28</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>2:30</b> P M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-52-6108</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>43</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3-11-48</b>   |  |
| 8. BIRTHPLACE (State or Foreign)<br><b>Md.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>BON SECOUR HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2842 HARLEM AVE.</b>  |  |  |  | 10f. ZIP CODE<br><b>21216</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9TH</b><br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DISABLED</b>             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Nursing Assistant</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ROY BARFIELD</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LULA MAE HILL</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROY BARFIELD</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2842 HARLEM AVE./BALTIMORE, MD 21216</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>ANNE ARUNDEL CO., MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septicemia</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Acquired Immodeficiency Syndrome</b><br><b>End stage Renal Disease</b><br><b>Bacterial Endocarditis, staph</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>multiple decubitus ulcers</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D16263</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/28/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JUAN A. BELTRAN, MD 1940 W. BALT. ST, BALT MD 21223</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>SYLVIA E CARTER</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>08</u> DAY <u>31</u> YEAR <u>91</u>  |  | 3. TIME OF DEATH<br><u>08:08 AM</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>173-20-6036</u>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>66</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>10-30-24</u>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>NORTH ARUNDEL HOSPITAL ASSOCIATION</u>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>GLEN BURNIE</u>   |  | 9c. COUNTY OF DEATH<br><u>A.A. COUNTY</u>   |  |
| 10a. STATE<br><u>MD</u>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><u>SEVERNA</u>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><u>6 Kimerely Court</u>   |  |  |  | 10f. ZIP CODE<br><u>21146</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>Black</u>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12th Grade</u> College (1-4 or 5+) <u>Homemaker</u>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Homemaker</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Unknown</u>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Nancy Walker</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>James Hunt Funeral Home</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>126 Ridge Avenue/Ashberry Pk., N.J. 21146</u>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Woodbine Cemetery</u>  |  | DATE  |  | 20c. LOCATION — City or Town, State<br><u>Monmouth Co., N.J.</u>                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Francis J. Shaw</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>WM.C. MARCH F.H. 1101 E. NORTH AVE.</u>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Carcinoma of Colon, Metastatic</u>   |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> LOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Paul M. Rosoff, M.D.</u>  |  |  |  | 29c. LICENSE NUMBER<br><u>D 17640</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>8/31/91</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 20 (Type/Print)<br><u>PAUL M. ROSOFF, M.D. 7755 RITCHIE HIGHWAY, SE/GLEN BURNIE, MARYLAND 21061</u>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 3 1991</u>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked for item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KENNETH D CARTER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>6:55 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-70-1954</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>32</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9/3/58</b>                             |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 8c. COUNTY OF DEATH<br><b>BALTO., MD</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                             |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>4612 BELVIEU AVENUE</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21207</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN CARTER</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HERMENER McNEAL</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HERMENER McNEAL</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4612 BELVIEU AVENUE BALTIMORE, MD 21207</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  | 20d. DATE  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME</b><br><b>4600 LIBERTY HEIGHTS AVENUE 21207</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>liver cirrhosis, hepatic encephalopathy</b><br><b>Alcoholism</b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. Ochaney</i><br><b>MEDICAL HOUSE OFFICER</b><br><b>LIBERTY MEDICAL CENTER</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 40521</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/31/91</b>                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. OCHANAY</b><br><b>LIBERTY MEDICAL CENTER</b><br><b>2600 LIBERTY HEIGHTS AVENUE</b><br><b>BALTIMORE, MD 21215</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Roland E. Corey</b>   |  | 2. DATE OF DEATH<br>MONTH <b>August</b> DAY <b>30</b> , YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>9 PM</b> M  |  |
| 4. <b>263-05-3837</b><br><del>263-05-2051</del>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> <b>74</b> YRS.   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 30 1916</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Montana</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>602 Maryland Ave.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>602 Maryland Ave.</b>   |  | 10f. ZIP CODE<br><b>21221</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mechanic</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Aero-Space</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Herbert W. Corey</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hulda Davis</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary A. Corey, Wife</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>602 Maryland Ave. Baltimore, Md. 21221</b>   |  |  |  |
| 20a. MANNER OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Belair Memorial Gardens 9/3/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Belair, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdzinski Funeral Home PA</b><br><b>1407 Eastern Ave. Balto., Md. 21221</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Pleural effusion, massive Rt.</b><br><b>Pulmonary Carcinomatosis</b><br><b>COPD</b> |  | Approximate Interval Between Onset and Death<br><b>1 day</b><br><b>1 month</b><br><b>? 2+ months</b>   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.   |  | 29c. LICENSE NUMBER<br><b>D01021</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>8-31-91</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>205 Fuzelaye Avenue Baltimore, Md. 21220</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |



91 23849

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALFRED H. DONEGAN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>4:00 A.</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-30-4671</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 18, 1905</b>                                      |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>AUSTRIA</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>4616 YORK ROAD</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>                                      |   |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>4616 YORK ROAD</b>  |  |  |  | 10f. ZIP CODE<br><b>21212</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>8</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>GOV'T INVESTIGATOR</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. GOV'T. C.I.A.</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ALFRED W. DONEGAN</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HERMA ZIGLER</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY C. DONEGAN</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4616 YORK ROAD. BALTIMORE, MD. 21212</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>PARKWOOD MAUSOLEUM</b> DATE <b>9/3/91</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD. 21234</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. J. Ruth</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HENRY W. JENKINS &amp; SONS</b><br><b>4905 YORK RD., BALTO., MD. 21212</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic skin Carcinoma to Stomach</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>1 month</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                      |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Charles A. Padgett M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-15546</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-31-91</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHARLES A. PADGETT M.D., 5601 LOCH RAVEN BLVD. BALTO. MD. 21239</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John F. Davidson</b>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>LILLIAN MURN DAWSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>SEPTEMBER</b> DAY <b>2</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>8:20 P.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-74-3594</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JULY 7, 1899</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>2561 CARROLLTON ROAD</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS</b>  |  |
| 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>ANNAPOLIS</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2561 CARROLLTON ROAD</b>  |  |
| 10f. ZIP CODE<br><b>21403</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>TELEPHONE OPERATOR</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>TELEPHONE COMPANY</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last) <b>SPENCER CHRISTOPHER VIETT</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BESSIE ALEXIZINA HAMMETT</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>GARY BARNUM (SON-IN-LAW)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2561 CARROLLTON ROAD, ANNAPOLIS, MARYLAND 21403</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>NEW CATHEDRAL CEMETERY</b> DATE <b>9/6/91</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES</b><br><b>1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic cancer of the cervix</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>acute stenosis</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>congestive heart failure</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. Approximate Interval Between Onset and Death |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIED BY PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29c. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> physician  |  |  |  |
| 29d. LICENSE NUMBER<br><b>D29769</b>   |  |  |  | 29e. DATE SIGNED (Month, Day, Year)<br><b>9/3/91</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARCELINO D. ALBUERNE M.D. 516 N. ROLLING ROAD SUITE 205 BALTIMORE, MD. 21228</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02557 10

*James H. Lawrence*

91 23851

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DOROTHY S. DISNEY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>SEPTEMBER</b> DAY <b>2</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>6:55 am</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-22-1738</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>83</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 24, 1908</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>JENKINS MEMORIAL HOME</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  | 9c. COUNTY OF DEATH<br><b>--</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>CATONSVILLE</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>9 MONROE FIELD COURT</b>   |  |  |  | 10f. ZIP CODE<br><b>21228</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>BOOK BINDER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>STATIONARY</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE WASHINGTON STALLINGS</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SADIE RICARD</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY HUESMAN (DAUGHTER)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9 MONROE FIELD CT. CATONSVILLE MD. 21228</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park 9/5/91</b>                          |  | 20c. LOCATION — City or Town, State<br><b>BALTO. MD.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Laurence M.D.</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES<br/>1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. multi stroke disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>arteriosclerotic disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Laurence M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>DO1786</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-3-91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LAURENCE GALLAGER M.D. 3455 WILKENS AVENUE SUITE 300 BALTIMORE, MD. 21228</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876C, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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*Handwritten signature or text, possibly "J. L. Smith"*



91 23852

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>IRIS N. EDER</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>1:05 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-76-7848</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10-25-1918</b>                                 |  |
| 8a. FACILITY NAME (If not Institution, give street and number)<br><b>FRANCIS SCOTT KEY MEDICAL CENTER</b>  |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>AUSTRALIA</b>                                |  |
| 9a. RESIDENCE OF DECEDENT<br><b>MARYLAND</b>   |  |   |  | 9b. COUNTY<br><b>BALTIMORE</b>  |  | 9c. CITY, TOWN OR LOCATION<br><b>DUNDALK</b>  |  |
| 10a. STATE   |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>2047 KEIMORE ROAD</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21222</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 8+) <b>N/A</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOME MAKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>NOT KNOWN TILBROOK</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>NOT KNOWN</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>VERNON W. EDER</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2047 KEIMORE ROAD BALTIMORE, MARYLAND 21222</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HOLLY HILL MEMORIAL 9-3-1991</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Chad W. Fisher</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DUDA-RUCK FUNERAL HOME OF DUNDALK INC.<br/>7922 WISE AVENUE DUNDALK MD 21222</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pneumonia</b>  |  |   |  |   |  |   |  |
| b. <b>Metastatic Carcinoma of Breast</b>   |  |   |  |   |  |   |  |
| Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |   |  |   |  |
| c. <b>Due to (or as a consequence of):</b>   |  |   |  |   |  |   |  |
| d. <b>Due to (or as a consequence of):</b>   |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Bronchitis</b>  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Larry W. Winkler, MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>DD 9557</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Alison Moliterno MD Francis Scott Key Med Center 4940 Eastern Ave Baltimore</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John T. ...</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SPR 10

91 23853

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Willard D. Fountain</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 28, 1991</b>  |  | 3. TIME OF DEATH<br><b>2:30 P. M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-48-4451</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 23, 1910</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>4-E Peabody Court</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4 -E Peabody Court</b>  |  |  |  | 10f. ZIP CODE<br><b>21234</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Franklin W. Dryden</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sarah M. Minor</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Janet P. Fountain</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same As #10</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp. 8-30-91</b>  |  | DATE<br><b>8-30-91</b>  |  | 20c. LOCATION — City or Town, State<br><b>Towson, Maryland 21204</b>                                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Wallace S. Brooks, Jr.</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Road, Towson, Md 21204</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of Lung</b>   |  |  |  |   |  |   |  |
| Due to (or as a consequence of):   |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| Due to (or as a consequence of):   |  |  |  |   |  |   |  |
| Due to (or as a consequence of):   |  |  |  |   |  |   |  |
| Due to (or as a consequence of):   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Jeffrey Cool</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D34650</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jeffrey Cool, M.D. 9712 Belair Road, Baltimore, Maryland 21236</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodriguez</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

681-15

681-15 1991 1-15

91 23854

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Milton Anselm Fisher</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 1, 1991</b>  |  | 3. TIME OF DEATH<br><b>7:45 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>082-14-5782</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>86 YRS.</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Mar. 25, 1905</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Broadmead</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cockeysville</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore Co.</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore Co.</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cockeysville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>13801 York Road</b>   |  |
| 10f. ZIP CODE<br><b>21030</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>College (1-4 or 5+)</b><br><b>4+ Years</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mathematics Teacher</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>High School Education</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Fisher</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lena Blumenbath</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nancy R. Smith</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>169 Barbara Rd., Middletown, Ct. 06457</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Paul T. Lochstampfor</i><br><b>Paul T. Lochstampfor</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld, Inc.</b><br><b>10 W. Padonia Road, Timonium, Md. 21093</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |  |  |
| a. <i>Myocardial Infarct</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. <i>Hypertension</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. <i>Arteriosclerotic Cardiovascular Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| d.   |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Walter Hepner</i><br><b>Walter Hepner</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D23450</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/2/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Walter Hepner, M.D. 3313 Papermill Road, Phoenix, Maryland</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Gula Davidson-Randall</i><br><b>Gula Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN-MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 is marked, or item 30 is marked, the medical examiner must be notified at once.

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91 23855

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Anne B. Faulkner  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Aug. 28, 1991   |  | 3. TIME OF DEATH<br>M.  |   |
| 4. SOCIAL SECURITY NUMBER<br>220-22-1319  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>11/21/1908   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1958 Denbury Dr.  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Dundalk  |  | 9c. COUNTY OF DEATH<br>Balto. Co.   |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Dundalk  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>1958 Denbury Drive,   |  |  |  | 10f. ZIP CODE<br>21222  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8th Grade   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Housewife   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Crockett  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sarah Crockett Crockett  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Molly Dixon & Mary Martin  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1958 Denbury Drive, Baltimore, Maryland 21222  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Memorial Park 8/30                                 |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, Maryland  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Shane Savage   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Balto. Md. 21225 Ave.<br>McCully Funeral Home, 237 E. Patapsco  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Respiratory Arrest<br>DUE TO (OR AS A CONSEQUENCE OF) Progressive Alzheimer's Disease<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Theodore Patterson, MD  |  | 29c. LICENSE NUMBER<br>D 09643  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/28/91  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Theodore Patterson, MD 1576 Merritt Blvd., Baltimore, Maryland 21222   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Jill Davidson-Randall  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2-2-12

OK Order

1-1-12



91 23856

FOR  
STATE  
REGISTRAR **GENEVIEVE FRENCH** **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GENEVIEVE C. FRENCH</b>   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>02</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>3:00 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-34-1717</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br><b>57</b> YRS.   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOWARD COUNTY GENERAL HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COLUMBIA</b>  |  | 9c. COUNTY OF DEATH<br><b>HOWARD</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>HOWARD</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>COLUMBIA</b>   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>9349 WINDBELL WAY</b>  |  | 10f. ZIP CODE<br><b>21045</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>          |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECRETARY</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CATHOLIC CHURCH</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HARRY COHN</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARGARET</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOHN FRENCH (HUSBAND)</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9349 WINDBELL WAY COLUMBIA, MD 21045</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MEADOWRIDGE MEMORIAL PARK 09/04/91 DORSEY, MD</b>   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy M. Witzke</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROI M &amp; RUSSELL C WITZKE FUNERAL HOME<br/>5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |   |  |  |  |
| a. <i>Septic shock</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |
| b. <i>Liver Cancer</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |
| 24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John French</i>  |  | 29c. LICENSE NUMBER<br><b>022587</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/3/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HOWARD COUNTY GENERAL HOSPITAL, COLUMBIA, MD.</b>  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rendell</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form.

PAGES 1, 2, 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.

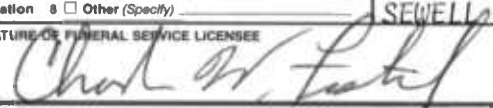
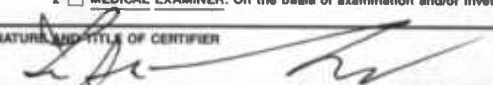

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100 100 100 100

91 23857

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Hazel Evelyn FLESHMAN</b>   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 1, 1991</b>   |  | 3. TIME OF DEATH<br><b>9:20 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-22-1019</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>1-22-1917</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROSSVILLE</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>DUNDALK</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1813 MARSHALL ROAD</b>  |  | 10f. ZIP CODE<br><b>21222</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES           |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>HIGH SCHOOL</b><br>College (1-4 or 5+) <b>N/A</b> |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOME MAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE BRAMMER</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY ELLA HASH</b>   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>ERNEST G. FLESHMAN</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1813 MARSHALL ROAD BALTIMORE, MARYLAND 21222</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SEWELL VALLEY BAPTIST 9-6-91</b>  |  | 20c. LOCATION — City or Town, State<br><b>RAINELLE, WEST VIRGINIA</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DUDA-RUCK FUNERAL HOME OF DUNDALK INC.<br/>7922 WISE AVENUE DUNDALK, MD 21222</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary Embolus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Deep Vein Thrombosis, Right Leg</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
|  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER<br><b>P-14221</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9.1.91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Tarique Firozvi, M.D. 9000 Franklin Square Drive Baltimore, MD. 21237</b>  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information on this death certificate is to be used for the purpose of recording the death and for the purpose of determining the cause of death. It is to be filled out by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Office of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WALTER FOGLE, Sr.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>29</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>1525</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>705121070</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 6, 1903</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |
| 9c. COUNTY OF DEATH<br><b>City</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>City</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>6000 Bertram Ave.</b>   |  |
| 10f. ZIP CODE<br><b>21214</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Chief Rate Clerk</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>B&amp;O Railroad</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter Hiram Fogle</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Agnes Crook</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Julia Ann James</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6000 Bertram Ave., Baltimore, MD. 21214</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cem. 8-31</b>   |  | 20c. LOCATION — City or Town, State<br><b>Overlea MD.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br/>6009 Harford Rd., Baltimore, MD. 21214</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Lung abscess</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Hepatic abscess</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>2 months</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>30 min.</b><br><b>4 weeks</b><br><b>2 months</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>Intern</b>  |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/29/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. B. Lankachandra, Intern House Officer, Good Samaritan Hospital.</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |   |   |   |
|---|--|--|--|---|--|--|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Elsie Ruth Garrett  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 28, 1991                                |   | 3. TIME OF DEATH<br>M   |   |   |
| 4. SOCIAL SECURITY NUMBER<br>212-05-1028  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 25, 1908                               |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>5610 York Road  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                                |   | 9c. COUNTY OF DEATH   |   |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |   |   |   |   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Phoenix  |  |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |   |
| 10e. STREET AND NUMBER<br>14607 Manor Rd.   |  |  |  | 10f. ZIP CODE<br>21131  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |   |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White |   |   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4 or 5+) 4   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION*<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Telephone Operator  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>C. & P. Telephone Co.             |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lester McFadden  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna Leight                     |   |   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ann G. Magalotti -  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as #10  |  |  |   |   |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Moreland Mem. Pk. Cemetery  |  | DATE<br>8/31/91   |  | 20c. LOCATION — City or Town, State<br>Parkville, Md.                                |   |   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>E. L. P.</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd., Towson, Md. 21204  |  |  |   |   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>myocardial infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>hypertension</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>ASCVD</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |   |   | Approximate Interval Between Onset and Death  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Frank Palmisano, M.D.</i>   |  |  |  |   |  | 29c. LICENSE NUMBER<br>D09475  |   | 29d. DATE SIGNED (Month, Day, Year)<br>8-28-91  |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Frank Palmisano M.D. 5122 Harford Road, Baltimore, Maryland 21214  |  |  |  |   |  |  |   |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991   |  | 32. REGISTRAR'S SIGNATURE<br><i>John K. ...</i>  |  |   |  |  |   |   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0026

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mr. Raymond George Jr.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>28</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>249-42-4808</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3-12-1935</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>S. C.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1512 NORTH WICK ROAD</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1512 North Wick Road</b>  |  |
| 10f. ZIP CODE<br><b>21218</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>   |  |  |  |
| 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>Md Division of Correction</b>  |  |  |  |
| 18. FATHER'S NAME (First, Middle, Last)<br><b>Raymond George, Sr</b>  |  |  |  | 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lula Mae Rich</b>  |  |  |  |
| 20. INFORMANT'S NAME (Type/Print)<br><b>Lois George</b>   |  |  |  | 21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1512 Northwick Road Baltimore, Md 21218</b>   |  |  |  |
| 22. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet 9391</b>  |  |  |  |
| 24. LOCATION — City or Town, State<br><b>Owings Mills, Md</b>   |  |  |  | 25. SIGNATURE OF FUNERAL SERVICE/LICENSEE<br><i>Hola March</i>   |  |  |  |
| 26. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 4300 Wabash Avenue</b>  |  |  |  | 27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Respiratory Failure</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Myocardial Ischemic Disease</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Alcoholic Liver Disease</b> |  |  |  |
| 28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alcoholic Liver Disease</b>  |  |  |  | 29. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 31. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 32. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 33. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  |
| 34. DATE OF INJURY (Month, Day, Year)   |  |  |  | 35. TIME OF INJURY<br><b>M</b>   |  |  |  |
| 36. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 37. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 39. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 40. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 41. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  |
| 42. LICENSE NUMBER<br><b>724240</b>   |  |  |  | 43. DATE SIGNED (Month, Day, Year)<br><b>8/25/91</b>   |  |  |  |
| 44. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Michael H. Blum, Russell Morgan Prof. Bldg, 5601 Loch Raven Blvd Baltimore 21235</b>  |  |  |  |  |  |  |  |
| 45. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 46. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23861

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>AKA Marie Blake Gribble<br>Ethel Marie Blake Gribble   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>08-30-91   |  | 3. TIME OF DEATH<br>12:15 P. M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>185-18-1732   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>86 YRS.  |  | 7. DATE OF BIRTH (Month/Day/Year)<br>Aug 17, 1905  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Saint Joseph's Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson  |  |
| 9c. COUNTY OF DEATH<br>Baltimore County  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore County  |  |
| 10c. CITY, TOWN OR LOCATION<br>Sparks  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>13820 York Road  |  |
| 10f. ZIP CODE<br>21152   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 years<br>College (1-4 or 5+) _____   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Seamstress   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Clothing Manufacturing   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry Silbaugh Blake  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Minnie Holland  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Harry Winfield Gribble, Sr.  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13820 York Road, Sparks, Maryland 21152   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Sandy Hill Cemetery 9/3/91  |  | 20c. LOCATION — City or Town, State<br>Uniontown, PA   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Martin D. Lawson  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Dulaney Valley Home of Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd Timonium, Maryland 21093  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute 2-sided CVA<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| b. ASCVD<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d. _____<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>N/A  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mark S. Kaplan M.D.   |  |  |  | 29c. LICENSE NUMBER<br>D19155  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/30/91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARK S. KAPLAN M.D. 16918 York Rd. Monkton MD 21111   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-21-19



91 23862

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Josephine-Viola-Grosscup</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Aug. 28, 1991</b>  |  | 3. TIME OF DEATH<br>c 4:00 A  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-07-0090</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5/10/1919</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5711 Redmond Street, 21225</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore (Brooklyn Park)</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore (Brooklyn Park)</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>5711 Redmond Street,</b>   |  |   |  | 10f. ZIP CODE<br><b>21225</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th Grade</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Housewife</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Carmine Albany</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Viola Martin Albany</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Richard F. Grosscup</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>PO BOX 1207 Stone Mountain, Ga., 30086-1207</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial Park 8/31/91</b>  |  | 20c. LOCATION — City or Town, State<br><b>Glen Burnie, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> <b>Kevin E. Ecker</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Brooklyn<br/>237 E. Patapsco Ave., Balto., Md. 21225</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. <i>Acute Myocardial Infarction</i>   |  |   |  |   |  |
|   |  | b. <i>Arteriosclerotic CVD.</i>   |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | c. _____  |  |   |  |   |  |
|   |  | d. _____  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension</i>   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Benjamin Beroann MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>000751</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-29-91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BENJAMIN BEROANN M.D. 606 HAMMONK LANE BALTIMORE MD 21225</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the death has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is indicated on item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000 12

91 23863

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SHELDON H. GOUKER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 29, 1991</b>  |  | 3. TIME OF DEATH<br><b>7:55 a.m. M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>160 16 4680</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 6, 1920</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md</b>   |  | 10b. COUNTY<br><b>Carroll</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Manchester</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>3121 Westminster St.</b>   |  |  |  | 10f. ZIP CODE<br><b>21002</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 6+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>TV Repairman</b>   |  | 16b. KING OF BUSINESS/INDUSTRY<br><b>Electronics</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Urban Utah Gouker</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Clem</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Laura S. Gouker</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3121 Westminster St Manchester Md</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Marburg Memorial Grdngs</b>   |  | 20c. LOCATION — City or Town, State, Zip Code<br><b>Hanover, Pa 21002</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Stephen K. Muller</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Wetzel Funeral Home Inc Hanover Pa</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypovolemic Shock 2' GI Bleed</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>3 Days</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ischemic Cardiomyopathy</b><br><b>COPD</b><br><b>ASN - Hemodialysis dependent</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mary L. Warner MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>SSN 415 90 8262</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/29/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARY L. WARNER MD / 600 N. Wolfe St / Baltimore MD 21205</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 9/8 1991</b>  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23864

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDWARD K. HENRY, JR.</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>2:30 A</b> <b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219 22 9746</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6/4/27</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>VA MEDICAL CENTER</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FORT HOWARD</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>TOWSON</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>908 STEVENSON LANE</b>   |  |   |  | 10f. ZIP CODE<br><b>21204</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Millwright</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>McCormick</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward K. Henry Sr.</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ethel Hortense Wiegel</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lorraine L. Henry</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>908 Stevenson Lane, Towson, Md. 21204</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Towson, Md. 21204</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>David D. Bellentine</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1050 York Rd. Towson, Md.<br/>Ruck Towson Funeral Home Inc. 21204</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SPASTIC QUADRIPLÉGIA</b><br><b>CLOSED HEAD INJURY</b> |  |   |  |   |  | Approximate interval between Onset and Death  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Bala S. Duggirala</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>D30528</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BALA S. DUGGIRALA, M.D., VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John L. ...</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RANDOLPH BOLLING HUBARD</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>28</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>10:45A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-34-8508</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JUNE 15, 1906</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENN</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>2506 Caves Road</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Owings Mills</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>OWINGS MILLS</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2506 CAVES ROAD</b>   |  |
| 10f. ZIP CODE<br><b>21117</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>AUS WW II</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify <b>WHITE</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>4yrs</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>COLONEL</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. ARMY</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ARCHIBALD BLAIR HUBARD</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CARLOTTA DORIS BARNEY</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>INA COCHRAN HUBARD</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2506 CAVES ROAD OWINGS MILLS, MARYLAND 21117</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>MONTICELLO 8/31/91</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>CHARLOTTESVILLE, VA</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R H Ruth</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>HENRY W JENKINS &amp; SONS 4905 YORK ROAD BALTIMORE, MARYLAND 21212</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Atherosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Metastatic Carcinoma</b>  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br><b>Head Only</b>   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Margaret D. Koron RN</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-29-1991</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARGARET D. KORON RN 111 Penn Street, Baltimore, MD 21201</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 03 91</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23866

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BEATRICE CLAY HOLLOWELL</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>02</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>06:45 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-18-4978</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07 16 1905</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>   |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>  |  |   |  |
| 10. CITY, TOWN OR LOCATION OF DEATH<br><b>GLEN BURNIE</b>   |  |  |  | 11. COUNTY OF DEATH<br><b>A.A. COUNTY</b>   |  |   |  |
| 12. RESIDENCE OF DECEDENT   |  |  |  | 13. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |
| 14a. STATE<br><b>MD</b>   |  | 14b. COUNTY<br><b>ANNE ARUNDEL</b>   |  | 14c. CITY, TOWN OR LOCATION<br><b>GLEN BURNIE</b>   |  | 14d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 15. STREET AND NUMBER<br><b>612 OAKWOOD ROAD</b>  |  |  |  | 16. ZIP CODE<br><b>21061</b>  |  | 17. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 18. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 19. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 21. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 22. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>UNKNOWN</b><br>College (1-4 or 5+) <b>UNKNOWN</b>   |  | 23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>  |  | 24. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>  |  |   |  |
| 25. FATHER'S NAME (First, Middle, Last)<br><b>UNKNOWN MATTHEWS</b>  |  |  |  | 26. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>   |  |   |  |
| 27. INFORMANT'S NAME (Type/Print)<br><b>WILLIAM B. HOLLOWELL, SR.</b>   |  |  |  | 28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>612 OAKWOOD ROAD GLEN BURNIE, MD 21061</b>   |  |   |  |
| 29. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>FIRST BAPTIST CEMETERY</b>  |  | 31. DATE<br><b>9-5</b>  |  | 32. LOCATION — City or Town, State<br><b>POCOMOKE CITY, MD</b>                                  |  |
| 33. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. George Hyslop</i>  |  |  |  | 34. NAME AND ADDRESS OF FACILITY<br><b>SINGLETON FUNERAL HOME</b><br><b>1 SECOND AVE. S.W. GLEN BURNIE, MD 21061</b>  |  |   |  |
| 35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of cervix</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |
| 36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 37. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 38. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 39. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide<br>4 <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined   |  | 40. DATE OF INJURY (Month, Day, Year)  |  | 41. TIME OF INJURY<br><b>M</b>  |  | 42. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                 |  |
| 43. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 44. DESCRIBE NOW INJURY OCCURRED  |  |   |  |
| 45. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 46. 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 47. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 48. LICENSE NUMBER<br><b>219512</b>   |  | 49. DATE SIGNED (Month, Day, Year)<br><b>9-2-91</b>   |  |
| 50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SANG C. DOH, M.D./1600 CRAIN HWY., SW., #206/GLEN BURNIE, MARYLAND 21061</b>  |  |  |  |   |  |   |  |
| 51. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 52. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROSS L. HUTCHINS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>31</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>10:46 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>44</b> YRS. | 7. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>26</b> YEAR <b>46</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>305 FONT HILL AVENUE</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MD.</b>   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>305 Font Hill Avenue</b>  |  | 10f. ZIP CODE<br><b>21223</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Inspector</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ross Hutchins</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Louise Eggleston</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Louise Mitchell</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>415 E. 22nd St. Balto., MD. 21218</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Mem. Park 9-7-91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Arbutus, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Doretha Hector #281</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. Phillips F/H 1721-27 N. Monroe St. Balto., MD. 21217</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>   |  |  |  |  |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Donald G. Wright MD</b>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09/02/91</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DONALD G. WRIGHT MD DCME 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John F. ...</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.









91 23869

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Leonard Mowbray Howard</b>  |  |   |  | 2. DATE OF DEATH<br><b>09 - 02 - 91</b>   |  | 3. TIME OF DEATH<br><b>8:05A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-09-9872</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> O  |  | 6. AGE (In yrs. last birthday)<br><b>83</b>   |  | 7. DATE OF BIRTH<br><b>06-19-1908</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>COCKEYSVILLE</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>12 BEEHIVE PLACE</b>  |  |   |  | 10f. ZIP CODE<br><b>21030</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Veneer Cutter</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Roger Stenazer Veneer Co.</b>                              |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Walter Howard</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nannie B. Howard</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Vivian S. Howard</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 Beehive Place, Apt. D, Cockeysville, Md. 21030</b>                                       |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Jessops Cemetery</b>  |  | DATE<br><b></b>   |  | 20c. LOCATION — City or Town, State<br><b>Sparks, Md.</b>                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Paul T. Lochstampf</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld Timonium, Maryland 21093</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ISCHEMIC CEROBROVASCULAR ACCIDENT</b>   |  |   |  |   |  |   |  |
| Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |   |  |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF): <b>ATRIAL FIBRILLATION</b>   |  |   |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>A. Chakravarthy</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>34723</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/2/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHAKRAVARTHY, A. G.B.M.C.</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John H. ...</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

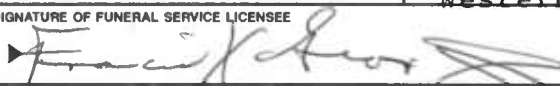
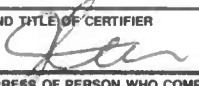
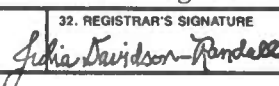
IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23870

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PHILLIP HALL</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>28</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>1625 p</b> <b>M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-62-2909</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>36</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-04-54</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>MD</b>  |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>613 Roundview Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21225</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Unemployed</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James C. Hall</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Audrey Gaines</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edith Hall</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>726 Deacon Hill Court/Baltimore, Md. 21225</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Western Star Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Md.</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C MARCH F.H. 1101 E. NORTH AVE.</b>  |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Septic Shock</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br>days<br>weeks   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertrophic Cardiomyopathy</b><br><b>Chronic Renal Failure</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br>3 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D30802</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-29-91</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Jean Colandrea - St. Agnes Hospital - 900 Caton Avenue - Baltimore, Md. 21229</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



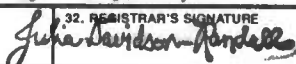
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANN MARGARET HUSS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Aug. 30, 1991</b>  |  | 3. TIME OF DEATH<br><b>8:35 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>546 34 5554</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 21, 1920</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>7146 Chandler Dr.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Berlin</b>  |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Worcester</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Berlin</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>7146 Chandler Dr.</b>  |  |  |  | 10f. ZIP CODE<br><b>21811</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nurse</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Retirement Infirmary</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Patrick Keane</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nora Curtin</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sandra Ann Nornes</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7146 Chandler Dr. Berlin, MD 21811</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cape Henlopen Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Frankford, DE</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>108 Williams St.<br/>Burbage Funeral Home Berlin, MD 21811</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |  |  |
|   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D26278</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/31/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David E. Connell MD 145 E. Connell St Solishy MD 21801</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be retained by the funeral director, page 5 should be retained by the funeral director, page 4 should be retained by the funeral director, page 3 should be retained by the funeral director, page 2 should be retained by the funeral director, page 1 should be retained by the funeral director.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by the funeral director, page 4 should be retained by the funeral director, page 3 should be retained by the funeral director, page 2 should be retained by the funeral director, page 1 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES H HUGHES</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>1991</b>  |  | 3. TIME OF DEATH<br><b>8:05 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>227-28-1378</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7 11 22</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>W. Va.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>3047 W. North Ave.</b>  |  |
| 10f. ZIP CODE<br><b>21216</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Henry Hugues</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Georgia Porter</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Annette Thomas</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6508 Woodbridgw Cir. Balto. 21228</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest Cemetery Owings Mills. Md.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>William M. Wainwright</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>2700 Edmondson Ave. Baltimore, Md. 21223</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br><b>Home only</b>  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>7 11 22</b>   |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Alonnie P. H. H. M.</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>O C M E</b>  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9-1-91</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Harry H. H. H. 111 N. PENN STREET BALTIMORE, MARYLAND 21201</b>  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 is marked, or item 28 is marked, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HILARY CHARLES JANISZEWSKI</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 29 1991</b>   |  | 3. TIME OF DEATH<br><b>10:30 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-28-5187</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>December 6, 29</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>545 Bayside Drive</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Dundalk</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Dundalk</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>545 Bayside Drive</b>  |  |  |  | 10f. ZIP CODE<br><b>21222</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Millwright</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Bethlehem Steel</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Janiszewski</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sophie Szczechowiak</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Janet M. Janiszewski</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>545 Bayside Drive Dundalk, Md. 21222</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp</b>   |  | 20c. LOCATION — City or Town, State<br><b>9/4 Towson, Maryland</b>  |  | 20d. DATE<br><b>9/4</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Chuck W. Fisher</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Avenue Dundalk, Md. 21222</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic Colon Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE NOW INJURY OCCURED  |  |  |  | 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29c. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>   |  |  |  |
| 29d. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29e. SIGNATURE AND TITLE OF CERTIFIER<br><i>Larry Waterbury, M.D.</i>   |  |  |  | 29f. LICENSE NUMBER<br><b>50 9559</b>   |  | 29g. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LARRY WATERBURY, MD. 4940 EASTERN, BALT., 21224</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The requirement that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Eddie Jenkins   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 31, 1991   |  |  |  | 3. TIME OF DEATH<br>4:55 P M  |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-44-4280  |  |  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>47 YRS.  |  | 7. DATE OF BIRTH (Month-Day-Year)<br>7-16-44  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                             |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Maryland General  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |   |  | 9c. COUNTY OF DEATH<br>none  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>none   |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore City   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1621 E. 29th Street   |  |  |  |   |  | 10f. ZIP CODE<br>21218   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced<br>Separated   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Negroid                           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th grade   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Corrugated Box Operator  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Box Co.   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Chick Jenkins  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Catherine Gorham  |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Walter Jeffries   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1005 N. Gay St. Balto, Maryland 21213 |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Calvary Cemetery 9/6/91  |  |  |  | 20c. LOCATION — City or Town, State<br>Maryland   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Calvin B. Scruggs Jr.</i>   |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Calvin B. Scruggs Funeral Home<br>1412 E. Preston Street, Balto, Md. 21213                         |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| a. Terminal Cancer of Lung metastasis to Brain  |  |  |  |   |  |  |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |   |  |  |  |   |  |
| b. Pneumonia  |  |  |  |   |  |  |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |   |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>C. Ngo, M.D.   |  |  |  |   |  | 29c. LICENSE NUMBER  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>August 31, 1991                           |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>C. Ngo, M.D. c/o Maryland General Hospital   |  |  |  |   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>  |  |  |  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FRANCIS PATRICK KALB, JR.</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>08</b> - DAY <b>30</b> - YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>9:00 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-07-8166</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>7-30-1902</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Joseph Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>4813 Walther Ave.</b>   |  |   |  | 10f. ZIP CODE<br><b>21214</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Pharmacist</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Francis P. Kalb, Sr.</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Geraldine Cross</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4813 Walther Ave., Balto., Md. 21214</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lakeview Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>9-3-91</b>  |  | 20d. LOCATION — City or Town, State<br><b>Sykesville, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Roy H. Cather</b><br><i>Roy H. Cather</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214</b>   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hemiplegia</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>Staph pneumonia</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arteriosclerotic cardiovascular disease</b>   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James A. [Signature]</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>115561</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>T. B. [Signature] 6201 W. Charles St. Baltimore MD 21212</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia [Signature]</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 53112



91 23876

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>William John Knoerlein</i><br><b>WILLIAM KNOERLEIN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>08</i> DAY <i>21</i> YEAR <i>91</i>   |  | 3. TIME OF DEATH<br><i>445 P M</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>213-05-5576</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>78</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>12 17 12</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Md.</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH HOSPITAL CORPORATION</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br><i>Md.</i>   |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>3220 Fait Avenue</i>  |  |
| 10f. ZIP CODE<br><i>21224</i>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Drydock Worker</i>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>U.S. Coast Guard</i>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Laurence Knoerlein</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Anna Snyder</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Anna M. Knoerlein</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3220 Fait Avenue Balto., Md. 21224</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Sacred Heart of Jesus Cem. 9-4-91 Dundalk, Md.</i>   |  |  |  |
| 20c. LOCATION — City or Town, State   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles S. Zeiler</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><i>Charles S. Zeiler &amp; Son Inc. 901 S. Conkling St.</i>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal Failure</i> <b>RENAL FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>obstructive uropathy</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br>27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined<br>28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>DR. ALAN SCHNEIDER</i><br>29c. LICENSE NUMBER<br><i>040611</i><br>29d. DATE SIGNED (Month, Day, Year)<br><i>8/31/91</i><br>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Alan Schneider 100 N Broadway, Balt Mo (Church Hospital)</i><br>31. DATE FILED (Month, Day, Year)<br><i>SEP 3 1991</i><br>32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i> |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REG. NO.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 23878

1 - FOR  
STATE  
REGISTRAR

REG. NO.

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|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Harry T. KELLY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>25</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>11:45 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>236-14-3418</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/14/12</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Western Maryland Center 1500 Pa Ave., Hagerstown Hagerstown, MD</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Washington</b>  |  | 9c. COUNTY OF DEATH<br><b>CHARLESTOWN, WV</b>   |  |
| 10a. STATE<br><b>VIRGINIA</b>  |  | 10b. COUNTY<br><b>FAIRFAX</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>CHANTILLY</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>13931 WESTMORE STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>22021</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>0</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>RETIRED MERCHANT</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>KELLYS STORE, STERLING, VA</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MARTIN KELLY</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SARAH EASTERDAY</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARGARET G. COVINGTON (NIECE)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9503 FOX CHASE DR., NOKESVILLE, VA 22123</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHESTNUT GROVE CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>HERNDON, VA</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>J. Berkley Green</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>P.O. BOX 385<br/>GREEN FUNERAL HOME, HERNDON, VA 22070</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>End stage renal disease +</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>Arteriosclerotic heart diseases</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>4 yrs</b><br><b>4 yrs</b> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Flora F. Palmo MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D21602</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/25/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. F. PALMO, WESTERN MARYLAND CENTER, 1500 PENNSYLVANIA AVE., HAGERSTOWN, MD 21742-3194</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, certified, or initialed, the medical examiner must be notified at once.



91-5031-510

#4, per F.H. 9/4/91 kam

91 23879

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM J KENNEDY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>2:40 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>271-16-8442</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3 27 '24</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Highlandtown</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>407 N. Highland Avenue</b>   |  | 10f. ZIP CODE<br><b>21224</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                 |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>10th</b>  |  |
| 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Steel worker</b>   |  |  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Reid Avery Co.</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Louis E. Kennedy</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gladys Ross</b>  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Marie K. Kennedy</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>(Wife) 407 N. Highland Avenue - Baltimore, MD. 21224</b> |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cemetery 9/4</b>  |  | 20c. LOCATION — City or Town, State<br><b>Owens Mills, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Walter Adamski</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>GRACE HALL FUNERAL HOME</b><br><b>1005 Dumbek Ave. 21224</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>1st DDD pulmonary</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>8-31-91</b>   |  | 28b. TIME OF INJURY<br><b>3:34 P M</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT BEATEN</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>162 N. ELLWOOD AVE</b>  |  |  |  | 29a. CERTIFIER<br>(Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Louise M. H. H. H.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>O C M E</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-1-91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARYANN D. H. H. H. 111 N. PENN STREET BALTIMORE, MARYLAND 21201</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the cause of death has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KATHLEEN MARY LaROSSA</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 28 1991</b>   |  | 3. TIME OF DEATH<br><b>10<sup>17</sup> P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-30-0339</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>56</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/5/1934</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St Joseph Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore Towson</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>5903 Carter Ave.</b>  |  |  |  | 10f. ZIP CODE<br><b>21214</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12 yr's</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank LaRossa</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carmela Foti</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Arlene Maresca</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10133 Glass House Ct. Ellicott City, Md 21042</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Cross Cem 9/3/91</b>  |  | 20c. LOCATION — City or Town, State<br><b>Brooklyn, N.Y.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Paul L. Hartsock, Jr.</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Baltimore, MD 21214</b><br><b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Chronic Obstructive Pulmonary Disease</b>  |  |  |  |   |  | years   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  | years   |  |
| b. <b>Marital Obesity</b>  |  |  |  |   |  |   |  |
| c. <b>Diabetes Mellitus</b>  |  |  |  |   |  |   |  |
| d. <b>Metastatic Adenocarcinoma</b>  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Richard D. Patten MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D39609</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/28/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. Patten, MD - St Joseph's Hospital 7620 York Rd Baltimore 21204</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rodale</b>  |  |   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 7, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HENRY H. LEBER   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 1 YEAR 91   |  | 3. TIME OF DEATH<br>6:10 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>218 26 2020   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F         |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>4 10 15   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>VA MEDICAL CENTER, FORT HOWARD  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FORT HOWARD, MD.  |  |
| 9c. COUNTY OF DEATH<br>BALTIMORE   |  |  |  | 10a. STATE<br>MARYLAND  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>BALTIMORE CITY  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>5007 GREENLEAF ROAD  |  |
| 10f. ZIP CODE<br>21210   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WORLD WAR II   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) 4   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>PUBLIC RELATIONS REP.   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>PUBLIC RELATIONS   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>CLAUDE LEBER  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARGARET JAEGER  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>CLINICAL RECORDS   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9600 NORTH POINT ROAD, BALTIMORE, MD. 21052  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>DRUID RIDGE CEMETERY  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD. 21208  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>R. J. But   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HENRY W. Jenkins & SONS<br>4905 York Rd., Baltimore, Md. 21212  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CONGESTIVE HEART FAILURE<br>DIABETES MELLITUS<br>P.V.D.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Marcia Kane MD  |  |  |  | 29c. LICENSE NUMBER<br>D26391   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/1/91  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Marcia Kane, M.D., VA Medical Center, Ft. Howard, Md. 21052   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Wendell  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANNIE M. LEWIS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>21:45</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>225-42-8732</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>58</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-26-1932</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1908 Poplar Grove Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21216</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5 +)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>L.P.N.</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Francis Scott Key</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>McClain Jones</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mable Fowlkes</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Vernell Lewis</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1908 Poplar Grove St. Balto., MD. 21216</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Jones Cemetery 9-6-91</b>                                  |  | 20c. LOCATION — City or Town, State<br><b>Burkesville, VA.</b>  |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Doretha Hector #281</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. Phillips F/H 1721-27 N. Monroe St. Balto., MD. 21217</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HASCD</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dennis J. Charles MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>O. C. M. E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>SEPT. 1, 1991</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 PENN STREET BALTIMORE, MARYLAND 21201</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Tucker-Rendell</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Maggie Lewis</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>250-68-8982</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-26-09</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>S.C.</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>4844 Claybury Avenue</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>Md</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>4844 Claybury Avenue</b>   |  | 10f. ZIP CODE<br><b>21206</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>10th Grade</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joe Gause</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Gause</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lois Bellamy</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2623 Beryl Avenue/ Baltimore Md. 21205</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Zion A.M.E. Ch. Cem.</b>   |  | 20c. LOCATION — City or Town, State<br><b>N. Myrtle Beach, SC</b>   |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Calvin L. Williams</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ASCVD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate interval Between Onset and Death<br><b>1/A</b> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia / Organic Brain Syndrome</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D18642</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/1/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. PARCAMENT, M.D. 5518-B PHILADELPHIA RD BALTIMORE, MD. 21237</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is required, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PATRICIA E. LEARY</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 30 1991</b>   |  | 3. TIME OF DEATH<br><b>3:00 A. M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-26-5197</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>62 YRS.</b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JAN. 10, 1929</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5407 HILDEBRAND COURT</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COLUMBIA</b>  |  | 9c. COUNTY OF DEATH<br><b>HOWARD</b>  |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>HOWARD</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>COLUMBIA</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>5407 HILDEBRAND COURT</b>  |  |   |  | 10f. ZIP CODE<br><b>21044</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>WORD PROCESSOR</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>WORD PROCESSOR</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.M.B.C.</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LAWRENCE LEARY</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>GERTRUDE SHANKS</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RICHARD BEVERUNGEN</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3070 ROGERS AVENUE, ELLICOTT CITY, MARYLAND 21043</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>NEW CATHEDRAL CEMETERY (9/3/91)</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES<br/>1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. RESPIRATORY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. EMPHYSEMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>nil</b><br><b>years</b>                                |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>glaucoma, thyroid disease</b>  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>DEPUTY MEDICAL EXAMINER HOWARD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D31473</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PATRYCE A. TOYE, MD 1165 HENLOCK CONE WAY ELLICOTT CITY, MD</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PATRICIA Marlene LAWRENCE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 1, 1991</b>  |  | 3. TIME OF DEATH<br><b>12:15P</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218 46 5711</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>45</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 14 1946</b>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Middle River</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO        |  |
| 10e. STREET AND NUMBER<br><b>210 Shagbark Rd.</b>   |  |  |  | 10f. ZIP CODE<br><b>21220</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary Secondary (0-12) <b>II</b> College (13-16 or 17+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James William Hedges</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Virgie Striebe</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ralph E. Lawrence, Husband</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>210 Shagbark Rd. Baltimore, Md. 21220</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br><b>Holly Hill Memorial Gardens 9/4/91</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Co., Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>▶</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdinski Funeral Home PA<br/>1407 Eastern Ave. Baltimore, Md. 21221</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. <b>Gram Negative Bacterial Sepsis</b>   |  |   |  |   |  |
|   |  | b. <b>Crohn's Disease</b>  |  |   |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | c. <b>Hemorrhagic Pancreatitis</b>   |  |   |  |   |  |
|   |  | d. <b>Acute Renal Insufficiency</b>  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mary L Warner MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>SN 41590846</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/1/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARY L WARNER MD / 600 N. Wolfe St. / Johns Hopkins Hosp / Baltimore 21205</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>9/1/91 SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attended physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELIZABETH G LIEBMAN</b>   |  |  |  | 2. DATE OF DEATH<br><b>08<sup>TH</sup> 30<sup>YR</sup> 91</b>   |  | 3. TIME OF DEATH<br><b>03:55 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-03-3258</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>02/07/11</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GLEN BURNIE</b>   |  | 9c. COUNTY OF DEATH<br><b>A.A. COUNTY</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>PASADENA</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1724 GRANDVIEW ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>21122</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECRETARY</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CHURCH</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE PEDDICORD</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ALMA C. LANG</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOAN L. TUCKER</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5922 ROBINDALE ROAD CATONSVILLE, MD. 21228</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN CEMETERY 9/2/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>GLEN BURNIE, MARYLAND</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>AMBROSE FUNERAL HOME, INC.<br/>1328 SULPHUR SPRING ROAD 21227</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Cardio pulmonary arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | Approximate Interval Between Onset and Death<br><b>Immediate</b>                                |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <b>myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | <b>Immediate</b>  |  |
|  |  | c. <b>Ischemic cardiomyopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  | <b>years</b>  |  |
|  |  | d. <b>atherosclerotic cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  | <b>years</b>  |  |
|  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>David Kaplan M.D.</b>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>IRA E. KAPLAN, M.D./7845 OAKWOOD RD #200/GLEN BURNIE, MARYLAND 21061</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELSIE MOLLOY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>02</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>8:50 A M</b>                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215 225 790</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/04/17</b>                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9. COUNTY OF DEATH  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, M.D.</b>   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                         |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>2720 BAKER ST.</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21216</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0-12</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOME MAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ALEXANDER MILBURN</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>NORA CHANEY</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MR. GEORGE C. MOLLOY</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2720 BAKER STREET BALTIMORE, MARYLAND 21216</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ST. NICHOLAS CEMETERY 9/10/91</b>                          |  | 20c. LOCATION — City or Town, State<br><b>DUVAL CO JACKSONVILLE, FLORIDA</b>  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Lewis T. Gwynn</b>      |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>LEWIS T. GWYNN FUNERAL HOME 21215-6393<br/>4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiorespiratory arrest</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Sepsis</b><br><b>Infected Foot ulcers</b><br><b>Diabetes Mellitus</b> |  |   |  |
| 24. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. DESCRIBE HOW INJURY OCCURRED                                       |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 28c. DATE SIGNED (Month, Day, Year)<br><b>9/2/91</b>  |  | 28d. DATE SIGNED (Month, Day, Year)                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Luis F. G. M. M.D.</b>  |  |   |  |
| 29c. LICENSE NUMBER<br><b>D31960</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/2/91</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LUIS F. GIMENEZ, M.D. 5301 Wd Nave Blvd 21239</b>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |   |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |                                |  |  |
|--|--|--|---|--|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary C. McGuire  |  |  |   | 2. DATE OF DEATH<br>MONTH 8 DAY 31 YEAR 1991   |                                | 3. TIME OF DEATH<br>6:35 P. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>217 03 8776   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>79 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br>3/16/1912   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |   | 9a. FACILITY NAME (If not institution, give street and number)<br>Meridian Hammond Lane Nursing Home   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore   |  |
| 9c. COUNTY OF DEATH<br>Anne Arundel  |  |  |   | 10a. STATE<br>Maryland   |                                | 10b. COUNTY<br>=====   |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |                                | 10e. STREET AND NUMBER<br>807 Pontiac Avenue   |  |
| 10f. ZIP CODE<br>21225   |  |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                                | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) 12th Grade<br>College (1-4 or 5+) _____   |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Cafeteria  |                                | 16b. KIND OF BUSINESS/INDUSTRY<br>Baltimore City School System   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Martin E. Gunning   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary C. Dukert  |                                |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Robert McGuire   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>612 Cleveland Road Linthicum, Maryland 21090  |                                |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holy Cross Cemetery 9-4   |                                | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>George J. Gonce Funeral Home P.A.<br>4001 Ritchie Hwy. Baltimore, Md. 21225  |                                |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Liver Insufficiency<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |   |  |                                |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Unfractionated heparin   |  |  |   |  |                                |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |                                |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |   | 28a. DATE OF INJURY (Month, Day, Year)   |                                | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |   | 28d. DESCRIBE HOW INJURY OCCURRED  |                                |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |                                |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Robert C. Dart, Jr. MD  |  |  |   | 29c. LICENSE NUMBER<br>D39660  |                                | 29d. DATE SIGNED (Month, Day, Year)<br>9/3/91  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Robert C. Dart, Jr. MD 3001 S. Hanover St Baltimore   |  |  |   |  |                                |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991  |  |  |   | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |                                |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22-50-12

91 23889

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET H. MATTHEWS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>1</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>1113</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-01-4545</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-10-1920</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>23 Luke Drive</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Pasadena</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Pasadena</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>23 Luke Drive</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21122</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>---</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elmer Reese</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Philip Matthews</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P. O. Box 1235 Sykesville, MD. 21784</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glen Haven Mem. Park 9/4/91 Glen Burnie, Md.</b>       |  | 20c. LOCATION — City or Town, State  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mc Cully Funeral Home of Pasadena<br/>3204 Mountain Rd. Pasadena, MD. 21122</b> |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Theresa L. Polymark</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mc Cully Funeral Home of Pasadena<br/>3204 Mountain Rd. Pasadena, MD. 21122</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Cardiac Insufficiency</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>ASCD</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                                      |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William R. Jones MD Deputy</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D06054</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/3/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William R. Jones MD P.O. Box 99 20711</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>   |  |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

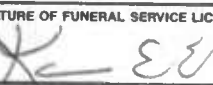
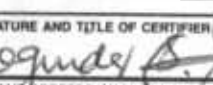
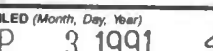
TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GERTRUDE DELORES MOORE</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>1991</b>  |  | 3. TIME OF DEATH<br><b>3:25 PM</b>   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-12-9586</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2/2/1902</b>                           |  |  |  |   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                     |  |  |  |   |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>  |  |   |  | 10a. STATE<br><b>Maryland</b>  |  |  |  |  |  |   |  |
| 10b. COUNTY<br><b>Anne Arundel</b>   |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>  |  |  |  |  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>6533 Pampano Drive,</b>   |  |  |  |  |  |   |  |
| 10f. ZIP CODE<br><b>21061</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES                                  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th Grade</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired Telephone Operator/ C&amp;P Telephone Co. of Md.</b> |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alric E. Tarlton</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret G. Heil Tarlton</b>   |  |  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. John H. Moore</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6533 Pampano Drive, Glen Burnie, Md. 21061</b>   |  |  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, INC. 9/4</b>   |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Maryland</b>  |  |  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> <b>Kevin E. Ecker</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Brooklyn<br/>237 E. Patapsco Ave., Balto., Md. 21225</b>  |  |  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Fungemia</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>Pancytopenia</b><br><b>Metastatic Breast Cancer</b> |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br><input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br><input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>House Staff</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/30/91</b>                           |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J.S. JODHKA, M.D., HARBOR HOSP. CENTER BALTIMORE M.D. 21230</b>  |  |   |  |  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br>                        |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>WILLIAM L. MAGWOOD  |  |  |  | 2. DATE OF DEATH<br>MONTH 08 DAY 31 YEAR 91   |  | 3. TIME OF DEATH<br>8:30 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>248-07-9542  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>72 YRS.   |  | 7. DATE OF BIRTH<br>MONTH 10 DAY 31 YEAR 18  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>5606 LIGHTSPUN LANE   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>COLUMBIA   |  | 9c. COUNTY OF DEATH<br>HOWARD  |  |
| 10a. STATE<br>MARYLAND  |  |  |  | 10b. COUNTY<br>HOWARD   |  | 10c. CITY, TOWN OR LOCATION<br>COLUMBIA  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>5606 LIGHTSPUN LANE   |  |  |  |
| 10f. ZIP CODE<br>21045  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 2   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>DEFENSE INTELLIGENCE  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. GOVERNMENT   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>WILLIAM L. MAGWOOD SR.   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LUCILLE HUTCHINSON   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>KATHERINE MAGWOOD (WIFE)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5606 LIGHTSPUN LANE COLUMBIA, MD 21045   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>COLUMBIA MEMORIAL PARK 09/04/91   |  | 20c. LOCATION — City or Town, State<br>COLUMBIA, MD   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy M. Witzke</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>LEROY M & RUSSELL C WITZKE FUNERAL HOME<br>5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Gastric Adenocarcinoma - metastatic stage IV</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>chronic anemia, Anorexia Cachexia Syndrome.</i>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jon K. Minford</i>  |  |  |  | 29c. LICENSE NUMBER<br>030573   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-3-91  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JON K. MINFORD M.D. 10632 LITTLE PATUXENT PARKWAY SUITE 424 COLUMBIA, MD 21044   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRAR DAVID WAYNE MARJARUM  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>David W. Marjarum</b>   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Aug 30, 1991</b>   |  | 3. TIME OF DEATH<br><b>5:44 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>516-34-0172</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br><b>57</b> YRS.  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Howard Cnty Gen. Hosp.</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia MD</b>   |  | 9c. COUNTY OF DEATH<br><b>Howard</b>  |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>HOWARD</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>CLARKSVILLE</b>   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>6801 REDBERRY ROAD</b>   |  | 10f. ZIP CODE<br><b>21029</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1952-1954</b> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>MANAGING LIBRARIAN</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>DEPARTMENT OF DEFENSE</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EDWARD W. MARJARUM</b>   |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ADA MAY ROGERS</b>   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>GAIL C. MARJARUM (WIFE)</b>   |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6801 REDBERRY RD. CLARKSVILLE MARYLAND 21029</b> |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>  |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE MD.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOME OF COLUMBIA<br/>5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND 21045</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiac arrest (asystole)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>recent M.I. and</b><br><b>advanced multiple myeloma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify): |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>G. S. Groman MD</b>  |  | 29c. LICENSE NUMBER<br><b>D34385</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>G. S. Groman, MD 2 Knoll N. Dr., Columbia, 21045</b>   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ROSE BERTHA McMANUS   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>8 - 31 - 91  |  | 3. TIME OF DEATH<br>5 20 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-24-8001  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F       |  | 6. AGE (In yrs. last birthday)<br>87 YRS.  |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br>11-15-1903   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>ST. JOSEPH HOSPITAL  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>TOWSON  |  |
| 9c. COUNTY OF DEATH<br>BALTIMORE  |  |  |  | 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>BALTIMORE   |  |
| 10c. CITY, TOWN OR LOCATION<br>DUNDALK  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>4320 CLAREWAY APT 31   |  |
| 10f. ZIP CODE<br>21213  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 6+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOME MAKER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>HOME   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>HEINRICH A. SCHULTZ  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>SOPHIE STETEFELDT   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARY LOUISE LLOYD   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12909 KILBURNIE CIRCLE FORT WASHINGTON MD 20744   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>SACRED HEART OF JESUS CEM 9-4-91  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Chen W. Lee</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>DUDA-RUCK FUNERAL HOME OF DUNDALK INC.<br>7922 WISE AVENUE DUNDALK MD 21222  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY FAILURE<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): SEPSIS<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>UPPER GASTROINTESTINAL BLEEDING   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |
| 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Francis Khoo STAFF MD</i>   |  |  |  | 29c. LICENSE NUMBER<br>D 30263   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8-31-91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANCIS KHOO, ST. JOSEPH HOSPITAL  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Guliana Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


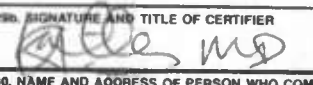
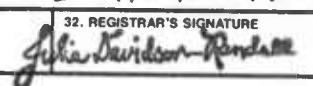
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>Kenneth James Mershon</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>23</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>12:35 A.M.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>526 46 6611</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 24, 1938</b>                                     |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE Johns Hopkins Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |   |
| 10a. STATE<br><b>Arizona</b>   |  | 10b. COUNTY<br><b>Maricopa</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Phoenix</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>202 W. Roma</b>   |  |  |  | 10f. ZIP CODE<br><b>85013</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Interior Design Architecture</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Architect</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Sequoyah Mershon</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Vera Karr</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Michael Mershon (brother)</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3631 W. Palo Verde Dr., Phoenix, AZ 85019</b>  |  |   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>East Resthaven Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Phoenix, Arizona</b>  |  | 20d. DATE<br><b>8/23/91</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Capitol Funeral Service<br/>Falls Church, VA</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>UNCONTROLLABLE GI BLEEDING</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>CHRONIC LIVER FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>HEPATITIS B INFECTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>2 DAYS</b><br><b>5 months</b><br><b>10 years</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RENAL FAILURE</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>KIRS ALLISON MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>J7968</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/23/91</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KIRS ALLISON MD 110 TOWER JOHNS HOPKINS HOSPITAL BALTIMORE MD 21205</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 8 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23895

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Mazcko</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 26 1991</b>  |  | 3. TIME OF DEATH<br>HOURS MINUTES AM/PM<br><b>6:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>166 09 9934</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. <b>72</b>   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct 24, 1918</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>105 Cedar Ave</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Berlin, Md</b>   |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>   |  |
| 10a. STATE<br><b>Md</b>   |  | 10b. COUNTY<br><b>Wicomico</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>107 Spinnaker Drive</b>  |  |  |  | 10f. ZIP CODE<br><b>21801</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Apartment owner operator</b>  |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>Rental</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Benny Mazcko</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Lovificer</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John O. Mazcko</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>105 Cedar Ave. Berlin, Md 21811</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sunset Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Berlin, Md</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burbage Funeral Home<br/>108 Williams St., Berlin, Md. 21811</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Non-small cell - Epidermoid Carcinoma Lung.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>TBR</b> |  |  |  |  |  | Approximate interval between Onset and Death  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <b>1</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>018614</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/28/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Deepak Saggat M. D. 547 Riverside Drive, Salisbury, Md. 21801</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |





91 23896

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Walter Prince Mallory  |  |  |  | 2. DATE OF DEATH<br>MONTH 8 DAY 28 YEAR 91  |  | 3. TIME OF DEATH<br>1545 P M   |   |
| 4. SOCIAL SECURITY NUMBER<br>242-22-1612   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>66 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>11-11-24                                      |   |
| 8. BIRTHPLACE (State or Foreign Country)   |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City, Md.  |  | 9c. COUNTY OF DEATH  |   |
| 9b. FACILITY NAME (If not institution, give street and number)<br>St. Agnes Hospital-900 Caton Ave   |  |  |  | 10a. STATE<br>MD.   |  |  |   |
| 10b. COUNTY<br>BALTIMORE   |  |  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  |  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>308 N. CULVER STREET-BALTIMORE, MD.   |  |  |   |
| 10f. ZIP CODE<br>21229   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>W.W.II   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                     |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>STURIVAN MALLORY  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>SARAH TAYLOR   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>JESSIE B. MALLORY (WIFE)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>308 N. CULVER STREET-BALTIMORE, MD. 21229  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARRISON FOREST V.A.  |  | 20c. DATE<br>9-3-91   |  | 20d. LOCATION — City or Town, State<br>BALTO CO MD                                   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Joseph L. Russ  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>JOSEPH L. RUSS F.H.<br>2222 W. NORTH AVE BALTO MD 21216   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary artery disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Hypertension<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Diabetes Mellitus<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br>years<br>years  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>D Boersma MD  |  |  |  | 29c. LICENSE NUMBER<br>D 40048  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/28/91                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>D BOERSMA MD 405 Frederick Rd #200 Catonsville MD 21228   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23897

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ELIZABETH REBECCA NELSON  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 03 1991   |  | 3. TIME OF DEATH<br>6:20 A M   |   |
| 4. SOCIAL SECURITY NUMBER<br>215-05-8886  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>79 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>03 06 1912   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>507 MUNROE CIRCLE  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>GLEN BURNIE   |   |
| 9c. COUNTY OF DEATH<br>ANNE ARUNDEL   |  |  |  | 10a. STATE<br>MD   |  | 10b. COUNTY<br>ANNE ARUNDEL  |   |
| 10c. CITY, TOWN OR LOCATION<br>GLEN BURNIE  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>507 MUNROE CIRCLE  |   |
| 10f. ZIP CODE<br>21061  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7<br>College (1-4 or 5+) NONE   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>FOOD PROCESSOR  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>GROCERY STORE BUSINESS   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>WILLIAM WILSON   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MAY LAIRD   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>HARRY W. NELSON   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>SAME AS 10  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GLEN HAVEN MEMORIAL PARK   |  | 20c. LOCATION — City or Town, State<br>GLEN BURNIE, MD   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 SECOND AVE. S.W. GLEN BURNIE, MD 21061   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Carcinomatosis, General</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><u>Carcinoma of lung</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><u>Paroxysmal atrial Flutter Fibrillation</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><u>Congestive heart Failure</u><br>Approximate Interval Between Onset and Death<br>1 yr<br>3 months<br>2 months |  |  |  |  |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension</u>   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Joseph Taler, M.D.</u>  |  |  |  | 29c. LICENSE NUMBER<br>D10820  |  | 29d. DATE SIGNED (Month, Day, Year)<br>Sept 3, 1991  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. JOSEPH TALER 95 AQUAHART ROAD, GLEN BURNIE, MD 21061   |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Arundel-Randall</u>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23898

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KATHLEEN A. OHL</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>28</b> YEAR <b>1991</b>  |  | 3. TIME OF DEATH<br><b>10:22A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>371-66-6167</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>35</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-14-1955</b>  |  |
| 6a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| 10a. STATE<br><b>Michigan</b>  |  |  |  | 10b. COUNTY<br><b>Wayne</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Allen Park</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>18722 Pinecrest Dr.</b>  |  |   |  |
| 10f. ZIP CODE<br><b>48101</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>Housekeeper</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housekeeper</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hotel</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John C. Ohl</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Audrey Newton</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John C. Ohl</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18722 Pinecrest Dr., Allen Park, MI 48101</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Slippery Rock Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Wayne Twp., PA.</b>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George Allen</b>  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br/>6009 Harford Rd., Baltimore, MD. 21214</b>   |  | 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Adult Respiratory Distress Syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Bone Marrow Transplant</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Chronic Myelogenous Leukemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO             |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 29a. CERTIFIER<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kathy D Miller MD</b>   |  |
| 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/28/91</b>   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kathy D Miller MD Tower 110 600 N Broadway Baltimore, MD</b>  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary S. Putens</b>  |  |  |  | 2. DATE OF DEATH<br>8-29-91  |  | 3. TIME OF DEATH<br>5:15 PM  |  |
| 4. SOCIAL SECURITY NUMBER<br>A<br>187-18-2027  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>69 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>7/17/22   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Hazelton, Pa.  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Stella Maris Hospice   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson  |  |
| 9c. COUNTY OF DEATH<br>Baltimore   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore   |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>7100 Rich Hill Rd.   |  |
| 10f. ZIP CODE<br>21212   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Buyer  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Baltimore County, Maryland   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Anthony Mikolajczyk   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Julia Budzinski   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Edward V. J. Putens  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8005 Brett Pl., Greenbelt, Md. 20770  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Dulaney Valley Mem. Gdns. 9/3/91  |  | 20c. LOCATION — City or Town, State<br>Timonium, Md.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Wallace S. Brady, Jr.   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd., Towson, Md. 21204   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cancer of Esophagus   |  |  |  |  |  |  |  |
| b. Metastatic Disease  |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dr. Eddie Vakhuda   |  |  |  | 29c. LICENSE NUMBER<br>19504   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/29/91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dulaney Valley Rd.<br>Stella Maris Hospice  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John L. ...   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2007-12

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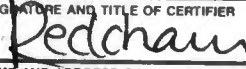
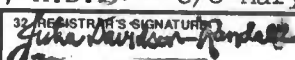
2007-12-12



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Valdur - Putsep</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 30, 1991</b>   |  |   |  | 3. TIME OF DEATH<br><b>11:42 P M</b>  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-32-4115</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 29, 1935</b>                                  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Estonia</b>  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Maryland General Hospital</b>   |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                    |  |   |  | 9c. COUNTY OF DEATH   |  |   |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>908 S. Baylis Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21224</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korea</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:<br><b>X</b>  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (8-12)</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Ret. Policeman</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore City</b>   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Putsep</b>   |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ljubov Meier</b>                        |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Fred Naarisma</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>908 S. Baylis Street Baltimore, Md. 21224</b>  |  |   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Sept. 5, 1991</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>  |  |   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Electromechanical dissociation Of Heart/ 30 minutes</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Coronary Artery Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |   |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |  | 28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Hassan Honainy, M.D.</b>  |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>N/A</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/31/91</b>   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Hassan Honainy, M.D. c/o Maryland General Hospital</b>   |  |   |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED<br><b>SEP 9 1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |   |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION


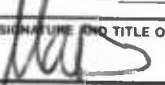
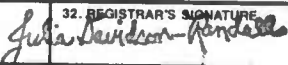
| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | REG. NO.   |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |  | 2. DATE OF DEATH  |  |  |  | 3. TIME OF DEATH   |  |
| VERGIE LEE PADGETT  |  |   |  | SEPT 01 1991  |  |  |  | 8 a.m.   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH   |  | 8. BIRTHPLACE (State or Foreign Country)                     |  |
| 226-12-9279   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F    |  | 75 YRS.   |  | 8-8-16   |  | TENNESSEE  |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH  |  |
| 715 BIRCH AVE   |  |   |  | PASADENA  |  |  |  | ANNE ARUNDEL CO.   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |  |  |  |
| 10a. STATE  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION   |  | 10d. INSIDE CITY LIMITS?   |  |  |  |
| MARYLAND  |  | ANNE ARUNDEL CO.  |  | PASADENA  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO      |  |  |  |
| 10e. STREET AND NUMBER  |  |   |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |  |  |
| 715 BIRCH AVE.  |  |   |  | 21122   |  | U.S.A.   |  |  |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?                             |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE — American Indian, Black, White, etc.                               |  |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | Specify: WHITE   |  |  |  |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | IF YES, GIVE WAR OR DATES   |  | Specify:  |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY                               |  |
| Elementary/Secondary (0-12) 12  |  |   |  | College (1-4 or 5+) NONE  |  |  |  | HOMEMAKER  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |  |  |
| THOMAS R. LLOYD   |  |   |  | ELIZA A. TITTLE   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  |  |  |  |
| JACK D. PADGETT, JR.  |  |   |  | 20 CRAIN HWY., NORTH GLEN BURNIE, MD 21061  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |  |  |  | 20c. LOCATION — City or Town, State                          |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  |   |  | GLEN HAVEN MEMORIAL PARK  |  |  |  | GLEN BURNIE, MD  |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  |   |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |  | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |  |  |
| R. George Harkin  |  |   |  | SINGLETON FUNERAL HOME  |  |  |  |  |  |
|   |  |   |  | 1 SECOND AVE S.W. GLEN BURNIE, MD. 21061  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death                 |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → ALZHEIMER'S DISEASE   |  |   |  |   |  |  |  | 5 YRS  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |   |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  |  |  |
| URINARY TRACT INFECTION   |  |   |  |   |  |  |  |  |  |
| ASPIRATION PNEUMONIA  |  |   |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?   |  |  |  |  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |   |  | 26. PLACE OF DEATH (Check only one)   |  |  |  |  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?   |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation  |  |   |  |   |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined   |  |   |  |   |  |  |  |  |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |  |  |
|   |  |   |  |   |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)   |  |   |  | 29b. LICENSE NUMBER   |  |  |  | 29c. DATE SIGNED (Month, Day, Year)                          |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                        |  |   |  | D21776  |  |  |  | 9/1/91   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |  |  |
| 29d. SIGNATURE AND TITLE OF CERTIFIER   |  |   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |  |  |
| S. Munda ATTENDING MD   |  |   |  | DR. SURYA MUNDRA 203 EAST PATAPSCO AVE. 21225   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |  | 32. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
| SEP 3 1991  |  |   |  | Julia Davidson-Randall  |  |  |  |  |  |

10-22 1<sup>st</sup>

91 23902

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>NANCY JEAN PFANSTIEL   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 01 1991  |  | 3. TIME OF DEATH<br>7:41 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>523-64-7729   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>45 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>02 02 1946  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>NEBRASKA   |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALITMORE CITY   |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>ANNE ARUNDEL  |  | 10c. CITY, TOWN OR LOCATION<br>GLEN BURNIE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>707 HYDE PARK DRIVE  |  |  |  | 10f. ZIP CODE<br>21061  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>THOMAS HOWERTER   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>W. CAROL MILLETT   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ROGER W. PFANSTIEL   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>SAME AS 10   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MARYLAND VETERANS CEMETERY 9-5  |  | 20c. LOCATION — City or Town, State<br>CROWNSVILLE, MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 SECOND AVE. S.W. GLEN BURNIE, MD 21061  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. SEPSIS  |  | DUE TO (OR AS A CONSEQUENCE OF):  |  | Approximate Interval Between Onset and Death<br>4 days  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. LEUKEMIA  |  | DUE TO (OR AS A CONSEQUENCE OF):  |  | 4 years   |  |
|  |  | c.   |  | DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |
|  |  | d.   |  | DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> FELLOW IN ONCOLOGY  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/1/91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>600 N. Wolfe Street<br>BALTIMORE, MD 21205  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR STATE REGISTRAR  
 1. **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**  
 REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HARRY C</b>  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>31</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>07:40 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-09-5196</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>5-26-1917</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GLEN BURNIE</b>   |  | 9c. COUNTY OF DEATH<br><b>A.A. COUNTY</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Pasadena</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>8567 Neptune Drive</b>   |  | 10f. ZIP CODE<br><b>21122</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>8</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrician</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Chemical Company</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harry C.</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Surfranick</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Joyce Oberdalloff</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8567 Neptune Drive Pasadena, MD. 21122</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery 9/3/91 Baltimore, MD.</b>   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mc Cully Funeral Home of Pasadena<br/>3204 Mountain Rd. Pasadena, Md. 21122</b>  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER<br><b>D 36900</b>  |  |
| 29d. DATE SIGNED (Month/Day/Year)<br><b>08/31/91</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KRISHAN K. SINGAL, M.D./1600 CRAIN HIGHWAY, #201/GLEN BURNIE, MARYLAND 21061</b>  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, the medical examiner must be notified at once.

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91 23904

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GLADYS PASHAL</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-30-91</b>   |  |  |  | 3. TIME OF DEATH<br><b>12: A.M.</b>   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>260-94-4848</b>  |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS. |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3-26-06</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>G.A.</b> |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5067 Glen Ave</b>   |  |  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO.</b>  |  |   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>md</b>  |  |  |  | 10b. COUNTY  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTO.</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>956 N. Chester St.</b>  |  |  |  |  |  |  |  | 10f. ZIP CODE<br><b>21205</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>            |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Negro</b>               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <input checked="" type="checkbox"/> College (14 or 5+) <input type="checkbox"/>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABOR</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Judge Cody</b>   |  |  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ellen Cody</b>  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Kathleen BAYANT</b>   |  |  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>956 N. Chester St. BALTO - MD 21205</b>   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>First Mt. Carmel Ch 9/6</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>Thomas G.A.</b>   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Betts Funeral Home</b>   |  |  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1129 N. Caroline St.</b>   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic Cancer of the stomach</b>  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF): <b>ischemic heart disease</b>  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF): <b>sacral decubitus ulcer</b>  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF): <b>massive left pleural effusion</b>   |  |  |  |  |  |  |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Respiratory insufficiency and to (C)</b>  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M                         |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED                       |  |  |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>physician</b>  |  |  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>D29769</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/1/91</b>    |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Margelino D. A. L. 516 W. Rolling Rd. Baltimore</b>  |  |  |  |  |  |  |  |   |  |   |  |  |  |
| 31. DATE OF DEATH (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91-4882-047

91 23905

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROLAND JAMES REMENTER, JR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>25</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>8:00 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>222-24-5203</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 18, 1939</b>                                     |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Delaware</b>  |  |  |  | 9. COUNTY OF DEATH<br><b>WICOMICO</b>   |  |   |  |
| 10. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA GENERAL HOSPITAL</b>  |  |  |  | 11. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |  |   |  |
| 10a. STATE<br><b>Delaware</b>  |  | 10b. COUNTY<br><b>Sussex</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Georgetown</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>RD 2 Box 215</b>  |  |  |  | 10f. ZIP CODE<br><b>19947</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>2</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Service Manager</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Automotive</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Roland James Rementer, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Esther Elizabeth Rawlins</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carol Rementer</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RD 2 Box 215, Georgetown, Delaware 19947</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Asbury Church Cemetery 8/29/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Georgetown, Delaware</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>William B. Carpenter</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Parsell, Dodd &amp; Carey Funeral Home<br/>307 N. Bedford St., Georgetown, DE 19947</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Wayne Meyhew</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-26-1991</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MSR Gordon D. W. Rose 111 N. PENN STREET BALTIMORE, MARYLAND 21201</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rendella</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91-4899-510

ITEMS: 23 thru 28f per ME

G-679 9/20/91 cm

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23906

|   |  |  |  |   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TILLMAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>26</b> YEAR <b>1991</b>  |  |  |  | 3. TIME OF DEATH<br><b>10:51 p.m.</b>   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-52-1624</b>   |  |  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>40</b> YRS. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10-12-50</b>                                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>S. Carolina</b>  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |   |  |   |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>2115 Fulton Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21217</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bus Driver/Gannt</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Mellard F. Robinson</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Allene Robinson</b>   |  |  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara Robinson</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4411 Springdale Ave. Balto., MD. 21207</b>  |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place)<br><b>Arbutus Mem. Park 8-30-91</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>Arbutus, MD.</b>                                      |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Doretha Hector #281</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. Phillips F/H 1721-27 N. Mohroe St. Balto., MD. 21217</b>  |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>NARCOTIC INTOXICATION</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br>c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br>d. |  |  |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input checked="" type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>8/26/91</b>   |  | 28b. TIME OF INJURY<br><b>UNKNOWN</b>            |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>UNKNOWN</b>   |  |   |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>UNKNOWN</b>  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>UNKNOWN</b>  |  |   |  |   |  |
| 29a. CERTIFIER<br>Check only<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. Davidson-Rendell MD</b>  |  |  |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/27/1991</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. Larson Wake MD 111 PENN STREET BALTIMORE, MARYLAND 21201</b>   |  |  |  |   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>  |  |  |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-10

1000-10

1000-10

1000-10

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>REUBEN A. RITTER</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>8</u> DAY <u>29</u> YEAR <u>91</u>   |  | 3. TIME OF DEATH<br><u>5:36 PM</u>  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>215 28 7586</u>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>61</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>5-29-30</u>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>MD.</u>   |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><u>BALTIMORE MD.</u>  |  | 10. COUNTY OF DEATH<br><u>TOWSON</u>  |  |
| 10a. STATE<br><u>Maryland</u>  |  | 10b. COUNTY<br><u>Baltimore City</u>   |  | 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><u>2920 Huntingdon Avenue</u>  |  |  |  | 10f. ZIP CODE<br><u>21211</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>white</u>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>Unknown</u><br>College (1-4 or 8+) <u>College</u>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Plumber</u>              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Plumbing</u>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Reuben A. Ritter</u>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Neoma Martha Strawburg</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Maurice A. Ritter</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>4202 Elsa Terrace, Baltimore, Md. 21211</u>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Lorraine Park Cemetery</u>                             |  | DATE<br><u>9/4</u>  |  | 20c. LOCATION — City or Town, State<br><u>Woodlawn Baltimore Co. Maryland</u>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Lynn Burge Henss</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Burgee-Henss Funeral Home</u><br><u>3631 Falls Rd. Baltimore, Maryland 21211</u>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Coronary artery disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><u>Probable ventricular arrhythmia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><u>Chronic heart failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><u>Aortic valve replacement, CABG</u><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Non-compliance with medicines and diet</u>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER<br>(Check one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>J. Douglas Clarke MD</u>   |  |  |  | 29c. LICENSE NUMBER<br><u>D31476</u>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>8/29/91</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>COEA MEDICAL ARTS BLDG. 7505 OSLER DR. Suite 214</u>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 3 1991</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Tawson MD 21204</u>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23908

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NATHANIEL RICE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 - 31 - 91</b>   |  | 3. TIME OF DEATH<br><b>7:22 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>248-52-9374</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08-25-35</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>South Carolina</b>  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Union Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>none</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>none</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1722 Abbotston St.</b>  |  |  |  | 10f. ZIP CODE<br><b>21218</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Negroid</b>                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>10th grade</b>  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Truck Driver</b>   |  | 16. KIND OF BUSINESS/INDUSTRY<br><b>Balto. Asphalt</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Rice</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carrie Hood</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Sarah Taylor</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1651 Freedomway-North, Balto, Md. 21213</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Baltimore Cemetery 9/8/91</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Calvin B. Scruggs Sr.</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Calvin B. Scruggs Funeral Home<br/>1412 E. Preston St. Balto, Md. 21213</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Variceal Esophageal Bleed</b>   |  |  |  |   |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| a. <b>Variceal Esophageal Bleed</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| b. <b>Bradycardia + Cardiac arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c. <b>Pulmonary Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d.   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Liver failure</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Julia Davidson-Randall</b>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/31/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Sign Print)<br><b>201 E. Univ Pkwy Balto, Md. Union Memorial Hosp</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

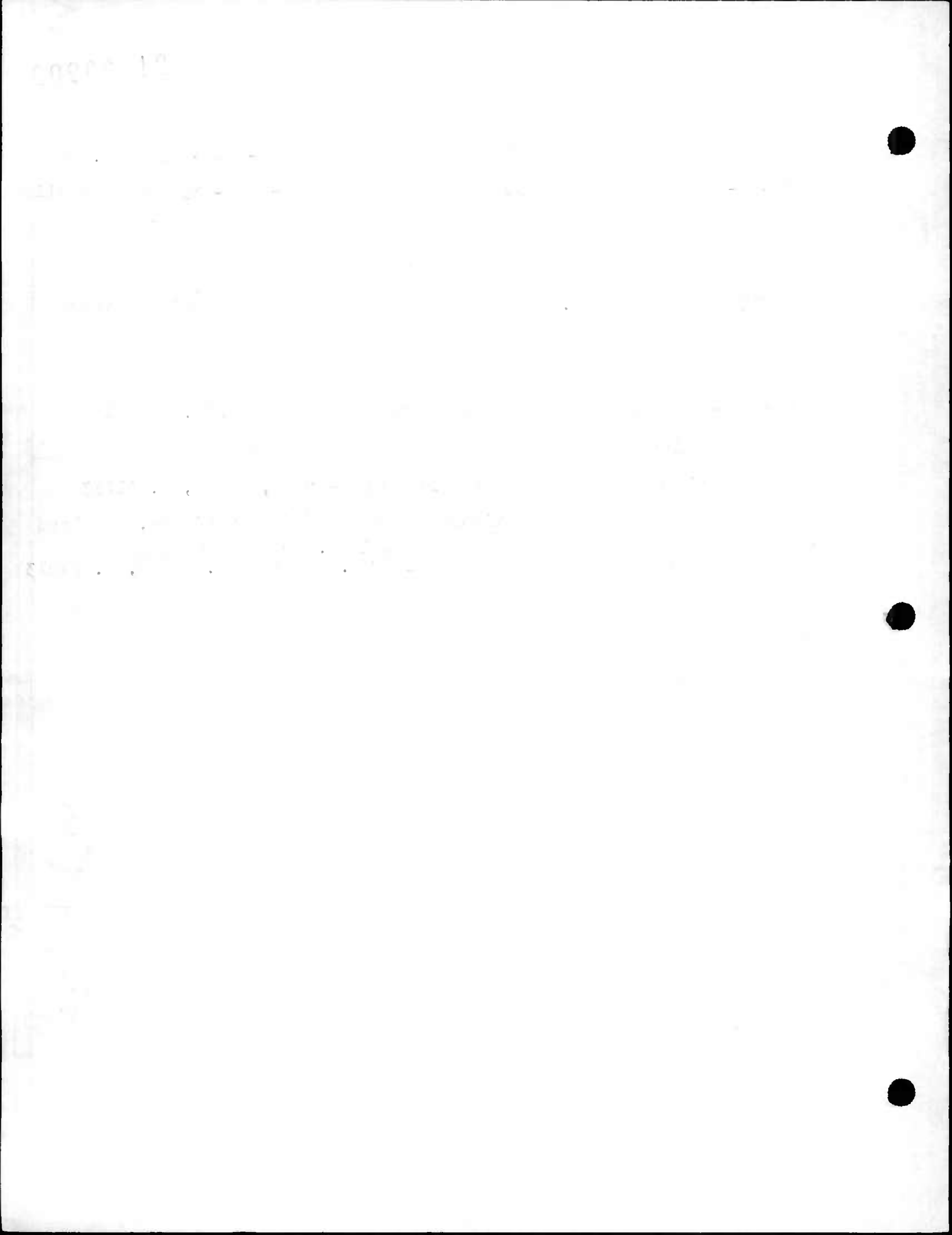
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 12



91 23909

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |
|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FRANK M. SCHULER</b>   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>01</b> YEAR <b>91</b>  |   | 3. TIME OF DEATH<br><b>545 A</b>  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-09-5718</b>   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 10, 1917</b>                                 | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. JOSEPH Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |   | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>Baltimore</b>   |   | 10c. CITY, TOWN OR LOCATION<br><b>Carney</b>  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>9615 Dixon Avenue</b>  |   |   |
| 10f. ZIP CODE<br><b>21234</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <b>X WW II</b>   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc.<br><b>White</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>  |   |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electroplater</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Schuler</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Nissler</b>  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles Schuler</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9615 Dixon Avenue Baltimore, Md. 21234</b>  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place)<br><b>Moreland Mem. Sept. 3, 1991</b>   |   | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James J. Bladden</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Prostate Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <b>Hyponatremia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide<br>4 <input type="checkbox"/> Homicide |   |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ashwani K. Basse</b>  |  | 29c. LICENSE NUMBER<br><b>D37250</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/1/91</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ASHWANI K. BASSE ST. JOSEPH HOSP. TOWSON MD.</b>  |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0920

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use on the funeral transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23910

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Arthur L Smith</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-29-1991</b>  |  | 3. TIME OF DEATH<br><b>1022 M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>241-14-9692</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-30-19</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sinai Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10a. STREET AND NUMBER<br><b>3800 W. Belvedere Ave</b>  |  |  |  | 10i. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Arthur L. Smith, Sr</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bertha Durham</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mildred Smith</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3800 W. Belvedere Ave Baltimore, MD 21215</b>   |  |   |  |
| 20a. MANNER OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest 9-4-91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Quilting Mills, Md</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dale March</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. West 4300 Wabash Ave</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic CARCINOMA of Prostate</b><br>Approximate Interval Between Onset and Death <b>2yr</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>gastric bleeding</b>   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Norman Mann</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D05210</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/29/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>NORMAN MANN - 3100 W. York Park Dr - Balto, Md</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES Norris STIGLER Jr.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>1</b> YEAR <b>1991</b>  |  | 3. TIME OF DEATH<br><b>02:45</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 62 6173</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>35</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-11-1955</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SHOCK TRAUMA/UNIVERSITY HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>=====</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>=====</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>304 Jack Street</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21225</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Viet Nam</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>9th Grade</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Manager</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Speedy Muffler</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James N. Stigler Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Estella Hines</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Stigler</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>304 Jack Street Baltimore, Maryland 21225</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Md. State Veterans Cem. 9-4</b>  |  | 20c. LOCATION — City or Town, State<br><b>Crownsville, Maryland</b>   |  | 20d. DATE<br><b>9-4</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jerome Znamionowski</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Hwy. Baltimore, Md. 21225</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Head Injuries with Complications</b><br>DUE TO (OR AS A CONSEQUENCE OF)<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated event resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>24a. WAS AN AUTOPSY PERFORMED?</b><br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br><b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b><br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input checked="" type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide <b>4</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8-21-1991</b>   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>OPERATOR OF MOTORCYCLE</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>RECK-STREET</b>   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>600 BLK.W.PATAPSCO AVENUE</b>  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stennis J. Chute MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>O. C. M. E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-1-1991</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 PENN STREET BALTIMORE, MARYLAND 21201</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jake Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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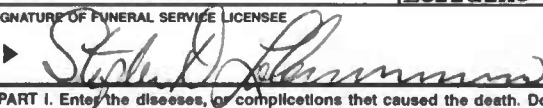
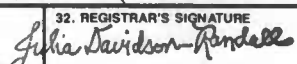
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Norman E. Stamp</b>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 31 1991</b>  |  | 3. TIME OF DEATH<br>M<br><b>M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215 01 1678</b>   |  | 5. SEX<br><b>1</b> M <b>2</b> F  |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.   |   |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>June 14, 1912</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1812 Chesapeake Rd.</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Pasadena</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>   |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Pasadena</b>   |   |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO  |  | 10e. STREET AND NUMBER<br><b>1812 Chesapeake Rd.</b>   |  | 10f. ZIP CODE<br><b>21122</b>  |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES<br><b>World War II</b> |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (8-12)</b><br><b>12</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Claims Manager</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Insurance Co.</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert Stamp</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rose Graeffe</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Thelma M. Stamp</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1812 Chesapeake Rd., Pasadena, MD 21122</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cemetery 9/3/91</b>  |  | 20c. LOCATION — City or Town, State<br><b>Woodlawn, MD</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Pasadena<br/>3204 Mountain Rd., Pasadena, MD 21122</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MESENTERIC CANCER OF COLON</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  | Approximate Interval Between Onset and Death<br><b>12 YRS</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____   |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined |  |  |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>MD</b>  |  | 29c. LICENSE NUMBER<br><b>D13999</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-31-91</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MICHAEL B. PSALIMAN MD</b>  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, on item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Mamie Stewart</i>   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>08 31 91</i>   |  | 3. TIME OF DEATH<br><i>5:55p</i> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>214-36-9593</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>103</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>01-2-1888</i>                                      |  | 8. BIRTHPLACE (State or Foreign Country)   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Bon Secours Hospital</i>  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><i>md.</i>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER<br><i>311 N. Schroeder St</i>   |  |  |  | 10f. ZIP CODE<br><i>21223</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:                                      |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>—</i> College (14 or 5+) <i>—</i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Housewife</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Henry Williams</i>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Georgiana Hall</i>                      |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Leon Johnson</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2234 W. Lexington St 21223</i>  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Arcturus mem. Park</i>   |  | 20c. LOCATION — City or Town, State<br><i>Arcturus, Md.</i>                                     |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John H. Powell</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>1206 W. North Ave 21217</i>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>Pneumonia &amp; Congestive Heart Failure</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><i>Generalized Arteriosclerosis</i> |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pneumonia Pulmonary Embolism</i>  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William H. Davidson, MD</i>  |  |  |  |   |  | 29c. LICENSE NUMBER<br><i>004872</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>8/31/91</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Bon Secours Hospital</i>   |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 3 1991</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rondelle</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1950

91 23914

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |                                 |   |  |   |   |  |   |  |
|---|--|--|---------------------------------|---|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ARMON SAMUELS</b>  |  |  |                                 | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 2, 1991</b>  |  |   |   | 3. TIME OF DEATH<br>10 a m   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>264-34-6482</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |                                 | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MARCH 3, 1915</b>             |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>PANAMA</b>  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>6321 MONIKA PLACE</b>  |  |  |                                 | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>WOODLAWN</b>  |  |   |   | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |  | 10b. COUNTY<br><b>BALTIMORE</b> |   |  | 10c. CITY, TOWN OR LOCATION<br><b>WOODLAWN</b>                          |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6321 MONIKA PLACE</b>  |  |  |                                 |   |  | 10f. ZIP CODE<br><b>21207</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b> |                                 | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |                                 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>STEEL WORKER</b>   |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BETHLEHEM STEEL</b>                |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MURDOCK</b>   |  |  |                                 |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>EVA SAMUELS</b> |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROZITA SAMUELS (DAUGHTER)</b>  |  |  |                                 | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6321 MONIKA PLACE APT. 301 WOODLAWN MD. 21207</b>   |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |                                 | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY 9/3/91</b>   |  |   | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE MD.</b>           |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |                                 | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOME<br/>1630 EDMONDSON AVE. BALTIMORE MARYLAND 21228</b>   |  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Acquired Immunodeficiency Syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Human Immunodeficiency Virus - I Infection</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |                                 |   |  |   |   | Approximate Interval Between Onset and Death<br><b>7 years</b><br><b>7 years</b>   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____  |  |  |                                 |   |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |                                 |   |  |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |                                 | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 9 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                  |   | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                 | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED                                       |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |                                 | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Paul S. Mueller MD</i>  |  | 29c. LICENSE NUMBER<br><b>PENDING</b>                                   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>September 2, 1991</b>  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PAUL S. MUELLER, MD Johns Hopkins Hospital Balto, MD 21205</b>  |  |  |                                 |   |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |                                 | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23915

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEPH FRANCIS SMITH</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>1</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>1:00</b> P M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-18-6193</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1/8/22</b>                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD--US</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>VA MEDICAL CENTER, Ft. HOWARD, MD</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FT. HOWARD</b>                         |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 10a. STATE<br><b>MD</b>   |  |  |  |
| 10b. COUNTY<br><b>BALTIMORE</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>DUNDALK</b>   |  |  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>8232 KAVANAGH RD. BALTIMORE</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21222</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b><br>College (1-4 or 5+) <b>N/A</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>TRUCK DRIVER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>COMMERCE DISTRIBUTORS</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM SMITH</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARGARET BARRY</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SHARON LEE FOX</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1403A SAGE LANE BELCAMP, MARYLAND 21017</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH CEM. 9-4-1991</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles W. Lich</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DUDA-RUCK FUNERAL HOME OF DUNDALK INC.<br/>7922 WISE AVENUE DUNDALK, MD 21222</b>   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br><b>ISCHEMIC CARDIOMYOPATHY</b><br><b>HYPERTENSION</b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Marcia Kane MD</i>   |  | 29c. LICENSE NUMBER<br><b>D26391</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/1/91</b>                             |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARCIA KANE, M.D. VA MEDICAL CENTER, FT. HOWARD, MD. 21052</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.





91 23916

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lucia Najman Shabasson</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>28</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>0730 A-M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>138 32 1393</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 26, 1918</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington Adventist Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Takoma Park</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>1111 University Boulevard, West</b>  |  |   |  |
| 10f. ZIP CODE<br><b>20902</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12 years</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel Najman</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Frumet Goodman</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lewis Shabasson</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Maryland 20902</b><br><b>1111 University Boulevard, West, Silver Spring,</b>                |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Judean Memorial Gardens 8/29/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Olney, Maryland</b>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald C. Stettin</b>   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>STEIN HEBREW MEMORIAL FUNERAL HOME</b><br><b>232 CARROLL STREET, N.W., WASHINGTON, D.C.</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Metastatic Adenocarcinoma of Pancreas</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                               |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                   |  |
| 26. PLACE OF DEATH (Check only one)<br><b>HOSPITAL:</b><br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br><b>OTHER:</b><br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Thomas A. Bensinger MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D08754</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/29/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Thomas A. Bensinger MD 7525 Greenway Center Drive Greenbelt MD 20770</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Jill Davidson-Rendell</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Amos Spencer</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>7:30 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>237-22-7637</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4/2/10</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |   |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Bethesda</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>5721 Grosvenor Place</b>  |  |
| 10f. ZIP CODE<br><b>20814</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Haymore Spencer</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Lambert</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Emily Spencer</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10a.b.c.d.e.&amp;f</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)<br><b>Ft. Lincoln</b>   |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Md</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Juan Smith</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John T Rhines Co., Inc.</b><br><b>3015 12th St NE, DC 20017</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b>  |  |   |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |  |  |  |  |
| b. <b>Coronary Arteriosclerosis</b>  |  |   |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |  |  |
| c. <b>Belmonary Tuberculosis</b>   |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |   |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br><b>HOSPITAL:</b><br><b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br><b>OTHER:</b><br><b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>6</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>8</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |  |   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John T. Rhines</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D58546</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-1-91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John T. Rhines</b>   |  |   |  |  |  |  |  |
| 31. DATE OF DEATH (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

11

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GENEVIEVE THOMPSON</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>21</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>2:00 p m</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-10-1513</b>   |  | 5. SEX<br><b>1 M 2 F</b>  |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9 12-1907</b>                   |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  |   |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 10. COUNTY OF DEATH<br><b>BALTIMORE</b>                                      |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>                                |  |
| 10e. STREET AND NUMBER<br><b>1323 E. Eager Street</b>   |  |   |  | 10f. ZIP CODE<br><b>21205</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1 YES 2 NO</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                       |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Goldsborough</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Laura Blake</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carl Thompson</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1323 E. Eager Street Balto., MD. 21205</b>          |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Mem. Park 8-26-91</b>                                     |  | 20c. LOCATION — City or Town, State<br><b>Arbutus, MD.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Vertha S. S. S.</i>   |  | #281  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. Phillips F/H 1721-27 N. Monroe St. Balto., MD. 21217</b>                                 |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. <b>Pulmonary edema - CHF - congestive heart failure</b>  |  |  |  | Approximate interval between Onset and Death<br><b>days 10</b>               |  |
|   |  | b. <b>MI - myocardial infarction</b>  |  |  |  | <b>1wk</b>   |  |
|   |  | c. <b>cardiomyopathy.</b>   |  |  |  | <b>YRS - 2</b>   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | d.  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b>  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |  |  |  |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                                    |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Helen S. Barold MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>57954</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/21/91</b>                        |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Helen S Barold, MD Johns Hopkins Hospital 600 N. Wolfe St. 21205</b>  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 7, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS:28a thru 28f per ME  
G-680 10/22/91 cm  
91-5029-025

91 23919

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT H THOMAS</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>5:16 PM</b>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>208-18-8382</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12-29-1926</b>                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FALLSTON GENERAL HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FALSTON</b>   |  |   | 9c. COUNTY OF DEATH<br><b>HARFORD</b>  |   |  |
| 10a. STATE<br><b>Pennsylvania</b>  |  | 10b. COUNTY<br><b>Berks</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Reading</b>   |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>737 Philadelphia Avenue</b>   |  |   |  | 10f. ZIP CODE<br><b>19607</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                       |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br><b>1944-1946</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>8th grade</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Welder</b>  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dana Corp.</b>                                  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Thomas</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lizzie Marks</b>  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Florence M. Thomas</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>737 Philadelphia Avenue Reading, Pa. 19607</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Forest Hills Mem. Ph.</b>   |  | DATE<br><b>9-6</b>  |  | 20c. LOCATION — City or Town, State<br><b>Exeter Township, Pa.</b>                          |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Duda-Ruck Funeral Home of Dundalk Inc.<br/>7922 Wise Avenue Baltimore, Md. 21222</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Drowning Complicating ASCVD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cirrhosis (Hemochromatosis) of Liver</b><br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify): |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>8/31/91</b>   |  | 28b. TIME OF INJURY<br><b>3:30p M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT DROWNED</b>     |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  | 29c. LICENSE NUMBER<br><b>O C M E</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-1-1991</b>                                      |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 N. PENN STREET BALTIMORE, MARYLAND 21201</b>   |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TYPE 12

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alice K Theiss</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>1400</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>061-18-0693</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-3-15</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1 Bristol Hill Court T-3</b>  |  |
| 10f. ZIP CODE<br><b>21228</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Registered Nurse</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Health Care</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Squire J. Kingston</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lena J. Sweeting</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Vincent P. Theiss</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1 Bristol Hill Court Catonsville, Md. 21228</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery 9/20/91</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ambrose Funeral Home, Inc.<br/>1328 Sulphur Spring Road 21227</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer c bone + liver metastasis</b><br>Approximate Interval Between Onset and Death <b>6 mo</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hepatic Failure</b>   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br><b>Limited</b>  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Wm. C. Waterfield MD</b>  |  | 29c. LICENSE NUMBER<br><b>024356</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Wm. C. Waterfield MD St Agnes Hosp 700 Catonsville Rd Balt Md 21229</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PERRY WHEELER WILLCOX</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 28, 1991</b>  |  | 3. TIME OF DEATH<br><b>11:45 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-22-2274</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-3-1927</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FRANCIS SCOTT KEY MEDICAL CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>MARYLAND</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>DUNDALK</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1952 DINEEN DRIVE</b>  |  |  |  | 10f. ZIP CODE<br><b>21222</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8 YEARS</b><br>College (1-4 or 5+) <b>N/A</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>CRANE OPERATOR</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BETHLEHEM STEEL CORP</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>PERRY WHEELER WILLCOX</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HELEN OLIVIA FUNK</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DORIS M. WHEELER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1952 DINEEN DRIVE BALTIMORE, MARYLAND 21222</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MEADOWRIDGE MEMORIAL 8-31-91</b>  |  | 20c. LOCATION — City or Town, State<br><b>DORSEY, MARYLAND</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles W. Lutz</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DUDA-RUCK FUNERAL HOME OF DUNDALK INC.<br/>7922 WISE AVENUE DUNDALK MD 21222</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. Presumed Abdominal Aortic Aneurysm Rupture</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Tobacco Abuse</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Atherosclerosis</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>15 minutes</b><br><b>30 yrs</b><br><b>60 yrs</b><br><b>10-20 yrs</b>                            |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal Failure - Dialysis Dependent</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Timothy M. Gardner</i>  |  | 29c. LICENSE NUMBER<br><b>H1857</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>8/28/91</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Timothy M. Gardner MD JHH 600 N. Wolfe St. Balt. MD 21205</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John L. Anderson</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-9146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.




IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Margaret WRIGHT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> -DAY <b>27</b> -YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>12:37 pm</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>178-124-816</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3 20 1915</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>White Marsh</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  | 10a. STATE<br><b>Md</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>2315 Chelsea Terrace</b>  |  |
| 10f. ZIP CODE<br><b>21216</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Food Processor</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Food Service</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Henry Simms</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Daisy Ann Moore</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rosetta Johnson</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2315 Chelsea Terrace Balto., Md. 21216</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Western Star Cemetery 9-3</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Catonsville Md.</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Derrick C. Jones F.H.<br/>4611 Park Heights Ave. Balto., Md. 15</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral Vascular Accident</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  |
| 29c. LICENSE NUMBER   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Stephen Needleman, MD 9000 Franklin Square Drive Baltimore, MD 21237</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be signed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JULIA ANN WHITE  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 - 02 - 91  |  | 3. TIME OF DEATH<br>1:22 A.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-36-0163   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>51 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>03-11-40   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>HARBOR HOSPITAL CENTER  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br>MD   |  |   |  | 10b. COUNTY<br>ANNE ARUNDEL   |  | 10c. CITY, TOWN OR LOCATION<br>GLEN BURNIE  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br>172 MORRIS COURT  |  | 10f. ZIP CODE<br>21060  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+) NONE  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>WILLIAM M WRIGHT  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ANNA CRAFF   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>VERNON F. WHITE, SR.   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>SAME AS 10   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>CEDAR HILL CEMETERY   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 SECOND AVE. S.W. GLEN BURNIE, MD 21061  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. LUNG CANCER<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. NEUTROPENIA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
|  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>J. V. Selvaraj MD. PHYSICIAN  |  |   |  | 29c. LICENSE NUMBER<br>AS244161463  |  | 29d. DATE SIGNED (Month, Day, Year)<br>09-02-91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>J. V. SELVARAJ MD 3001 SHANOVER ST. BALTIMORE MD 21230  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 3 1991  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23924

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WATTS - LEE LEE DAVIS WATTS</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>29</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>11:45AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>243-01-8662</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6/15/1906</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>N/A</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>N/A</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore (Brooklyn)</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3726 Saint Margaret St.,</b>  |  |   |  | 10f. ZIP CODE<br><b>21225</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>+3</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired Foreman</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Royster Chemical Co.</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James David Watts</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lavance Brookshire Watts</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Davidson C. Watts</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>330 Wende Way, Glen Burnie, Maryland 21061</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Pk. 9/3</b>  |  | 20c. LOCATION — City or Town, State<br><b>Elkridge, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kevin E. Ecker</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Brooklyn<br/>237 E. Patapsco Ave., Baltimore, Md. 21225</b>  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b>   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| b. <b>Ischemic Heart Disease episode MI</b>  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| c. <b>Atrial Fibrillation</b>  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| d. <b>Renal Insufficiency</b>  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mark Dennis MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D30555</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/29/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>3001 S. Hanover St Balto MD 21230</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JEANNE E. WEBER</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Aug 30 91</b>  |  | 3. TIME OF DEATH<br><b>850 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-12-1810</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-25-1921</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FRANCIS SCOTT KEY MEDICAL CENTER</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>DUNDALK</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7927 CHARLESMONT ROAD</b>   |  |   |  | 10f. ZIP CODE<br><b>21222</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12TH GRADE</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LAB TECHNICIAN</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>DUPONT</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM M. MILLER</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HAZEL HOWARD</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DANIEL SCOTT WEBER</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7927 CHARLESMONT ROAD BALTIMORE, MARYLAND 21222</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OAK LAWN CEMETERY 9-3-1991</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Chad W. Loh</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DUDA-RUCK FUNERAL HOME OF DUNDALK INC.<br/>7922 WISE AVENUE DUNDALK MD 21222</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b>  |  |   |  |   |  |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| b. <b>ESOPHAGEAL CANCER</b>  |  |   |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>6 weeks</b>  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NONE</b>  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Catherine Washburn</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>DA1298</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-30-91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FLOYD DAVID ARMSTRONG JR 660 N Wolfe St BALTIMORE, MD</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP/30/1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Galia Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18578 12


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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Elwood Wagoner</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 1, 1991</b>  |  |   |  | 3. TIME OF DEATH<br>M   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>234 48 2090</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 12, 1932</b>          |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Francis Scott Key Medical Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>-</b>   |  |  |  |
| 10a. STATE<br><b>Md.</b>   |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                         |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>422 Mirabile Lane</b>   |  |  |  | 10f. ZIP CODE<br><b>21224</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Korean</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5 +)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Heating-Air Cond. Mechanic</b>               |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hospital</b>                       |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Irvin Easter Wagoner</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Pownell</b>  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charolett J. Wagoner, Wife</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>422 Mirabile Lane Balto., Md. 21224</b>   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holly Hill Memorial Gardend 9/4/91 Baltimore Co., Md.</b>                  |  | DATE  |  | 20c. LOCATION — City or Town, State                                     |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdinski Funeral Home PA<br/>1407 Eastern Ave. Baltimore, Md. 21221</b>   |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Sudden cardiac death</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Coronary artery disease</b><br>c.<br>d.<br>Approximate interval Between Onset and Death <b>several (hours) 9/1/91</b> |  |  |  |   |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                                   |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                              |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28c. DESCRIBE HOW INJURY OCCURRED                                       |  |   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |  |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Joseph Adams MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D32783</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/3/91</b>                    |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Joseph Adams MD 7401 Oster Drive Towson, MD 21204</b>  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>9/3/91/SEP</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Gelia Davidson-Randall</b>   |  |   |  |   |  |   |  |  |  |



91 23927

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

216-10-8486

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WALKER Donald (Donald R. Walker)</b>   |  | 2. DATE OF DEATH 8-30-91<br>MONTH DAY YEAR  |  | 3. TIME OF DEATH 10:35 am   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 10 8486</b>   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  | 7. DATE OF BIRTH<br><b>1-25-05</b><br>MONTH DAY YEAR |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH HOSPITAL CORPORATION</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>none</b>  |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>none</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE City</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1605 N. Rutland Avenue</b>   |  | 10f. ZIP CODE<br><b>21213</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES          |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Negroid</b>  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th grade</b><br>College (1-4 or 5+) <b>none</b> |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Sealtest Western Maryland</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Walker</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Brooks</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marie B. Walker</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1605 N. Rutland Avenue Balto, Md. 21213</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Baltimore Cemetery 8/31/91</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Calvin B. Scruggs Jr.</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Calvin B. Scruggs Funeral Home<br/>1412 E. Preston St. Balto, Md. 21213</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>MASSIVE Cerebral Hemorrhage</b><br><b>Due to (or as a consequence of):</b><br><b>40 old MI TBP. Ca Prost.</b><br><b>LD. 7.1.95</b><br><b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>DR. TARIQUE FIROZVI, M.D.</b>   |  | 29c. LICENSE NUMBER<br><b>D14221</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8.30.91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. TARIQUE FIROZVI, M.D. CHURCH HOSPITAL CORPORATION</b>   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 3 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





ITEMS: 20b, 20c per FH  
G-679 9/5/91 cm

91 23928

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LEWIS AUSTIN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>31</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>10:48A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>226-18-8810</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3-27-16</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BALTIMORE COUNTY GENERAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>302 N. BRUCE STREET</b>  |  |  |  | 10f. ZIP CODE<br><b>21223</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATHS   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10TH</b><br>College (1-4 or 5+) <b>COLLEGE</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>FARM WORK</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HENRY AUSTIN</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VIRGINIA SHEPPER</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MILDRED MCCAIN</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>502 N. STRICKER ST. 1st FL./BALTO., MD 21223</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE<br><b>MT. Zion Cemetery</b><br><b>GARRISON FOREST V.A. CEM.</b>  |  | 20c. LOCATION<br><b>OWINGS MILLS, MD</b>  |  | 20d. DATE<br><b>08-31-91</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Shirley K. Jones</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C.MARCH F.H./1101 E. NORTH AVENUE</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Anemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anemia</b> |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>   |  | 28b. TIME OF INJURY<br><b>N/A</b> M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>N/A</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b>  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Shirley E. Jones, MD - Home office</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-39199</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-31-91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type and Print)<br><b>GRISelda E. Tiu, MD - 559 Traymore Ave., King of Prussia, PA 19406</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FARM WORK

101H

VIRGINIA SHEPPER

HENRY AUSTIN

505 N. STRICKER ST. 1st FL. BALTO., MD 21223

MILDRED MCCAIN

X

GARRISON FOREST V.A. CEM. OWINGS MILLS, MD

WM.C. MARCH F.H. VIOL E. NORTH AVENUE

*Agnes K. Jones*

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23929

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN BROWN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 8, 1991</b>  |  |  |  | 3. TIME OF DEATH<br>M<br><b>6:45 a.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-24-1698</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8-25-29</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>   |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>1113 GREENMOUNT AVENUE</b>  |  |  |  | 10f. ZIP CODE<br><b>21202</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b><br>College (1-4 or 5+) <b>COLLEGE</b>  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>NURSES AID</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM TIGGLE</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CORA NOGEN</b>   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>TRACEY BROWN</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1215 APPLELEAF CT./BALTIMORE, MD 21202</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEMETERY</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>M. L. Warner</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C.MARCH F.H./1101 E. NORTH AVENUE</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>Cardiac Arrest - unwitnessed Pulmonary embolism</b><br><b>Anteroposterior Myocardial Infarction</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8/31/91</b>   |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mary L. Warner MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>SSN 415 90 8462</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/31/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARY L. WARNER MD / 100 N. Wolfe St / Baltimore MD 21205</b>   |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>SEP 11 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Galia Davidson-Rendell</i>   |  |

21 38535

91 23930

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>ELIZABETH A. BARNES</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-30-91</b>  |  | 3. TIME OF DEATH<br><b>945 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>188-05-8164</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH<br>Month Day Year<br><b>APRIL 5, 1915</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNA.</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. JOSEPH HOSP.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO. MD</b>   |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |   |  | 10a. STATE<br><b>MD.</b>  |  |   |  |
| 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 10e. STREET AND NUMBER<br><b>4813 GALLEY ROAD</b>  |  |   |  | 10f. ZIP CODE<br><b>21236</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HARRY HOUSER</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>WILLIAM F. BARNES JR. (HUSBAND)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4813 GALLEY ROAD, BALTIMORE, MARYLAND 21236</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH</b>  |  | DATE  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOME INC.<br/>3331 Brehms Lane, Baltimore, Md. 21213</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CORONARY ARTERY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>STAFF MD  |  |   |  | 29c. LICENSE NUMBER<br><b>D30263</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-30-91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANCIS T. KHOO ST. JOSEPH HOSPITAL</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOUO: 100

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 23931

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alice M. Borgholte</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>3</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>0855</b> M  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-10-6260</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>96</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>AUG. 29, 1895</b>                   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Jenkins Memorial N. Home Inc.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balt'o.</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>---</b>   |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>---</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Balt'o.</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2881 MAYFIELD AVENUE</b>  |  |  |  | 10f. ZIP CODE<br><b>21213230</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>America</b>                                  |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>          |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>NA</b> College (1-4 or 5+) <b>NA</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sales Lady</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>DEPARTMENT STORE</b>                        |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Borgholte</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARGARET Lynch</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARGARET F. BOWLING (NIECE)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>600 LIGHT ST., APT 335, BALTIMORE, MD. 21230</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>new CATHEDRAL-# 00355</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>                     |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOMES, INC.<br/>3331 BREHMS LANE, BALTIMORE, MD. 21213</b>   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>URO SEPSIS</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>CEREBROVASCULAR DISEASE</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>RECENT HIP FRACTURE</b> |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)     |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William Russell MD</b>  |  | 29c. LICENSE NUMBER<br><b>D30172</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/3/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>100 WILLIAM RUSSELL MD 1000 S CATON AVE BAL MD</b>   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |   |  |

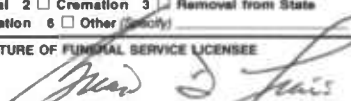
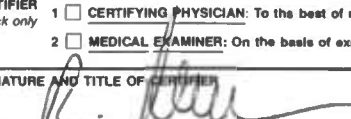
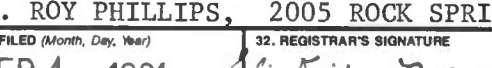
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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>JERRY ALBERT BARNHILL</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 31, 1991</b>  |  | 3. TIME OF DEATH<br><b>10:45 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-03-0137</b>  |  | 5. SEX<br><b>1 M 2 F</b>  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 9, 1902</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>SOUTH CAROLINA</b>                                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FALLSTON GENERAL HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FALLSTON</b>  |  | 9c. COUNTY OF DEATH<br><b>HARFORD</b>  |  |
| RESIDENCE OF DECEASED  |  |   |  |   |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>HARFORD</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>FALLSTON</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 X NO</b>  |  |
| 10e. STREET AND NUMBER<br><b>1660 ANGLESIDE ROAD</b>   |  |   |  | 10f. ZIP CODE<br><b>21047</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>  |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b><br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 X NO</b> Specify:     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                          |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>NA</b><br>College (1-4 or 5+) <b>NA</b>  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>GENERAL CONTRACTOR</b> |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN BUSINESS GENERAL CONTRACTING</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM BARNHILL</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANNIE ALLEN</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOSEPHINE BARNHILL (WIFE)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1660 ANGLESIDE ROAD, FALLSTON, MD 21047</b> |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OAK LAWN CEMETERY</b>                                      |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOMES, INC.<br/>9705 BELAIR ROAD, BALTIMORE, MD 21236</b>                              |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. <u>Metastatic Renal Cell Ca.</u></b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>  |  | 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>               |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>28b. TIME OF INJURY M</b><br><b>28c. INJURY AT WORK? 1 YES 2 NO</b>                                |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>            |  | 29c. LICENSE NUMBER<br><b>D022843</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/31/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. ROY PHILLIPS, 2005 ROCK SPRING ROAD, FOREST HILL, MD 21050</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br>                        |  |   |  |  |  |

**DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146**

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |                                |   |  |
|--|--|--|---|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>BLANCHE V. BEAN  |  |  |   | 2. DATE OF DEATH<br>MONTH 9 DAY 3 YEAR 91   |                                | 3. TIME OF DEATH<br>3:54 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>217-01-8573   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>73 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br>NOV. 21, 1917  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>5 WHALEN PARK COURT  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH   |                                | 9c. COUNTY OF DEATH<br>BALTIMORE  |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |                                |   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>BALTIMORE   |   | 10c. CITY, TOWN OR LOCATION   |                                | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>5 WHALEN PARK COURT  |  |  |   | 10f. ZIP CODE<br>21228  |                                | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12TH GRADE  |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>BEAUTICIAN  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>BEAUTY SALON  |                                |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>EDWARD LANDIS   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ALVERTA N. HILBERT   |                                |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>W. RAY BEAN  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5 WHALEN PARK COURT, BALTIMORE, MD. 21228  |                                |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>LOUDON PARK CEMETERY  |   | DATE<br>9/6   |                                | 20c. LOCATION — City or Town, State<br>BALTIMORE  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>M. Heald  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>HUBBARD FUNERAL HOME INC.<br>4107 WILKENS AVENUE, BALTIMORE, MD. 21229  |                                |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Emphysema<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. In Pulmonary<br>c. Dementia<br>d. Malnutrition |  |  |   |   |                                | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |                                | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |   |   |                                | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |                                |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |                                |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Joseph H Miller MD  |  |  |   | 29c. LICENSE NUMBER<br>A06982   |                                | 29d. DATE SIGNED (Month, Day, Year)<br>9/3/91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JOSEPH H MILLER MD 900 CATON AVE Baltimore Md 21229   |  |  |   |   |                                |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |   |   |                                |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FREDERICK W. BRANDT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 29, 1991</b>   |  | 3. TIME OF DEATH<br><b>4:00 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-07-5727</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10/27/1903</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>117 Versailles Cir. Apt. D</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>117 Versailles Cir. Apt. D</b>   |  |  |  | 10f. ZIP CODE<br><b>21204</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b><br>College (1-4 or 5+) <b>College</b>  |  |  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Comptroller</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Harry T. Campbell Sons</b>                                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Brandt</b>   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Amelia Erhardt</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles Brandt</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3401 Greenway Apt. 304 Baltimore, Md. 21218</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Mausoleum</b>   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lorraine Park 9/3</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert M. Kratz</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home<br/>6500 York Rd. 21212</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASCVD</b><br>Approximate Interval Between Onset and Death<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 26a. DATE OF INJURY (Month, Day, Year)   |  | 26b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO                     |  |
| 26c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 26d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 26e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Charles F. O'Donnell</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-09383</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/29/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Charles F. O'Donnell MD - 2301 Woodmont Rd. - Towson, Md. 21204</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23935

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Stanley Richard Cockrell, Jr.  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 01 1991  |  | 3. TIME OF DEATH<br>8:30 A  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-44-0401   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>45 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>12/03/45  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>2322 Eutaw Place 21217   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  |   |  | 9c. COUNTY OF DEATH<br>---  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>---  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>2322 Eutaw Place   |  |   |  | 10f. ZIP CODE<br>21217  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                       |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>2   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Hairdresser                        |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Hair Salon  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Stanley Richard Cockrell, Sr.   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Hinkey  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Harold D. Sampson  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2322 Eutaw Place Baltimore, MD 21217   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc. 9/2  |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George E. MacNabb</i><br>George E. MacNabb   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Cremation Society of Md., Inc.<br>299 Frederick Rd. Balto., MD 21228  |  |   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Rectal Lymphoma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Acquired Immunodeficiency Syndrome<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA                           |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                 |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Janet Horn</i>   |  |   |  | 29c. LICENSE NUMBER<br>D25169   |  | 29d. DATE SIGNED (Month, Day, Year)<br>09/02/91   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>SEBnet Horn, M.D., 5550 Newbury Street Baltimore, MD 21209  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>9/2   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |   |  |   |  |

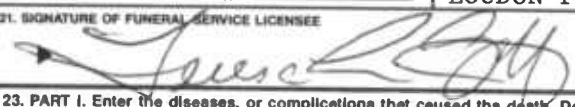
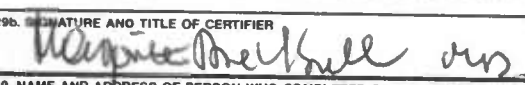
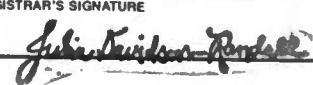
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES EDWARD CARY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>28</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>23:08</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-64-8573</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>35</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-1-1955</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br>-----  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>226 W. MONUMENT STREET</b>  |  |  |  | 10f. ZIP CODE<br><b>21201</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2 YRS COLLEGE</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>POSTAL WORKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. POSTAL SERVICE</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN EDWARD CARY</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CONCETTA LUCILLE LIBERTO</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CHARLES P. CARY</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>126 GARDEN RIDGE ROAD, CATONSVILLE, MD. 21228</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEMETERY</b>   |  | DATE<br><b>9/2</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE, BALTIMORE, MD. 21229</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>GUNSHOT WOUNDS TO CHEST AND ABDOMEN</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8-28-91</b>   |  | 28b. TIME OF INJURY<br><b>2220</b> M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT ASSAULTED &amp; SHOT</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>600 N. CHARLES/BALTO. CITY</b>   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>AUGUST 29, 1991</b>                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARYDAVID D. WASH</b> <b>111 PENN STREET BALTIMORE, MARYLAND 21201</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>REBECCA DAVIS</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>29</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>10:30 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215404494</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-03-1908</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH CORPORATION HOSPITAL</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3640 FOREST HILL ROAD</b>  |  |   |  | 10f. ZIP CODE<br><b>21207</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>RETIRED</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>WILLIE MCCAULEY</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2204 KOKO LANE, BALTO. MD. 21216</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE, MARYLAND</b>   |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charlene P. Brown</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 4433<br/>1913 W. BALTIMORE ST., BALTO. MD. 21223 P.O. BOX</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal Failure</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. <i>Dehydration</i><br>b. <i>CVA</i><br>c. <i>Seizure</i><br>d. <i>Hypertension</i><br><i>ASCVD</i> |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>W. Navarro MD Specialist</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D40356</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/29/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>W. NAVARRO 100 N. Broadway Balto. MD 21201</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3922

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 91 23938  |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LOIS B. DAVIDSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> - DAY <b>31</b> - YEAR <b>91</b>   |  |   |  | 3. TIME OF DEATH<br><b>8:13 P M</b>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>571-36-6666</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-23-18</b>                                       |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>W Va</b>   |  |  |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Stella Maris Hospice</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>506 Yarmouth Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21204</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>XX</b> |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b><br>College (1-4 or 5+) <b>4+ years</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>School Teacher</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Baltimore County</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lorenzo I. Davidson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Irma M. Terry</b>   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Cheryl Bowers</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13 Glen Gate Court Bel Air, MD 21014</b>  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>   |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Carla S. Alexander</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Johnson Funeral Home Balto., MD<br/>8521 Loch Raven Blvd. 21204</b>  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. METASTATIC STOMACH CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                          |  | OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>   |  | 26. PLACE OF DEATH (Check only one)   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Carla S. Alexander</b>   |  | 29c. LICENSE NUMBER<br><b>D 27087</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/31/91</b>                                       |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Carla S. Alexander, M.D.—Stella Maris Hospice—Dulaney Valley Rd. — Towson 21204</b>  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Johanna Davidson-Randall</b>  |  |   |  |   |  |  |  |

1995-96



91-5010-510

ITEM:6,7 per FH  
G-679 9/9/91 cm

91 23939

F.E.H.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>VINCENT E. DELANEY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>01:26</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-44-7010</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>47</b> YRS. | 7. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>12</b> YEAR <b>1944</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>N.Y.</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3533 Lucille Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (13-16) <input type="checkbox"/> 17 or more <input type="checkbox"/>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Carr Lowery Glass Co.</b>                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Vincent W. Delaney</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Aileen Morrell</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Yvonne Delaney</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3533 Lucille Avenue Baltimore, Md 21215</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>                              |  | DATE<br><b>9691</b>   |  | 20c. LOCATION — City or Town, State<br><b>Arbutus, Md</b>                                       |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James A. Thompson Jr</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F/H West<br/>4300 Wabash Avenue</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Stab Wound of Chest</i>  |  |  |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA               |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                              |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8-31-1991</b>   |  | 28b. TIME OF INJURY<br><b>0100 M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT ASSAULTED, STABBED</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>RESIDENCE</b>                                   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>4600 REISTERSTOWN RD.</b>  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James A. Thompson Jr</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>O. C. M. E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>AUGUST 31, 1991</b>                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 PENN STREET BALTIMORE, MARYLAND 21201</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rendell</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23940

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |  |  |
|--|--|--|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN ELBERT DUDLEY Jr.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>91</b>   |   | 3. TIME OF DEATH<br><b>0400</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>223-18-8478</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 2, 1917</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b> |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>355 Townsend Road</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>   |   | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>355 Townsend Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21221</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>43-45</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Beth Steel</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Elbert Dudley</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Wille Webb</b>  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Susie Dudley</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>355 Townsend Road Balto, Md. 21221</b>  |   |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holly Hill Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Md.</b>   |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Connelly Funeral Home</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ConnellyFuneralHome300MAceAve.21221</b>  |   |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Chronic ischemic myocardial disease</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |   | Approximate Interval Between Onset and Death<br><b>20 yrs.</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. Crossan O'Donovan</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>807632</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-30-91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. CROSSAN O'DONOVAN 2112 BUNDALK AVE., BALTO., MD.</b>  |  |  |  |   |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia...</i>   |  |   |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3148

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital and must be filed in the hospital's records. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

DHMH-16 Rev 1/89

في الحادي عشر من شهر ربيع الثاني سنة 1344 هـ

F.E.H.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JULIUS D. EVANS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>0037</b> <b>M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-06-1270</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>18</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-17-1973</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL/SHOCK TRAUMA</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH  |   |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>2049 Beechwood Ave.</b>  |  | 10f. ZIP CODE<br><b>21207</b>  |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>student</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |   |
| 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Marvin Parker</b>   |  |  |   |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Vivian Evans</b>   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Vivian Evans</b>   |  |  |   |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2049 Beechwood Ave. Balto. Md. 21207</b>   |  |  |  | 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |   |
| 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Western Star Cem. 9-5 Balto. Md.</b>   |  |  |  | 20c. LOCATION — City or Town, State   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Carlton C. Douglass</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Douglass Funeral Service<br/>1701 McCulloh St.</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>GUNSHOT WOUND OF CHEST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |   |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8-30-91</b>   |  | 28b. TIME OF INJURY<br><b>2200 M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   |
| 28d. DESCRIBE NOW INJURY OCCURRED<br><b>SUBJECT WAS SHOT</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>                        |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>2900 LAKE BROOK CIRCLE</b>   |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Douglas H. H. H.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>O. C. M. E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>AUGUST 31, 1991</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Wynne D. Koon M.D. 111 PENN STREET BALTIMORE, MARYLAND 21201</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Nellie E. Ferguson</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 03, 1991</b>   |  | 3. TIME OF DEATH<br><b>5:15 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>181-12-6784</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>04/30/02</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian/Brightwood N.H.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Brooklandville</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Timonium</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>215 Fallsbrook Road</b>   |  |
| 10f. ZIP CODE<br><b>21093</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William T. Simmons</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Clara Allwine</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Norma J. Anzio</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>215 Fallsbrook Road Timonium, MD 21093</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 9/4</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Md., Inc.<br/>299 Frederick Rd. Balto., MD 21228</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pancreatic Cancer with Metastasis</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>Pancreatic Cancer with Metastasis</b><br>b.<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9/4</b>  |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Alexander Bogdaschewskyi</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D37949</b>  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>09/04/91</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print)<br><b>Alexander Bogdaschewskyi, M.D. 1948 Liberty Rd. Sykesville, MD 21784</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |  |  |
|---|--|--|---|---|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EVELYN May FLYNN  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 03 91  |  | 3. TIME OF DEATH<br>450 A M   |  |  |
| 4. SOCIAL SECURITY NUMBER<br>25281418   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>59 YRS. |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>01/13/32 |   | 8. BIRTHPLACE (State or Foreign Country)<br>MD |  |
| 9a. GOOD SAMARITAN HOSPITAL   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE, MD  |  | 9c. COUNTY OF DEATH   |  |  |
| RESIDENCE OF DECEDENT   |  |  |   |   |  |   |  |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Baltimore   |   | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |
| 10e. STREET AND NUMBER<br>909 BACKRIVER NECK RD   |  |  |   | 10f. ZIP CODE<br>21221  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th<br>College (1-4 or 5+) College   |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Security Guard   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Fuller Sr.   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Evelyn May Hughes  |  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Cheryl Riley  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7929 Main Street Pasadena Maryland 21226   |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Moreland Memorial 9/6/91  |   | 20c. LOCATION — City or Town, State<br>Baltimore Md.  |  |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Connelly Funeral Home  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>ConnellyFuneralHome300MAceAve.21221   |  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BRAIN METASTASES<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. OAT CELL LUNG CANCER<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |   |   |  |   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Pneumonia   |  |  |   |   |  |   |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |   |   |  |   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY M   |  | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                   |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>JASON A. SORIANO, M.D.   |  |  |   | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>09/03/91   |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JASON A. SORIANO, M.D. GOOD SAMARITAN HOSPITAL, BALTIMORE, MD.   |  |  |   |   |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |   |   |  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Page 12

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23945

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Matty Estelle Griffith</b>   |  |   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 31 1991</b>  |  | 3. TIME OF DEATH<br><b>5:30 A. M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-30-7440</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>February 6, 1905</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3006 Dubois Avenue</b>   |  |   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Parkville</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Parkville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3006 Dubois Avenue</b>   |  |   |  | 10f. ZIP CODE<br><b>21234</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>School Teacher</b>  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Schools : Robert Poole &amp; Open Bible Day</b> |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Hugh O. Campbell</b>  |  |   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Cora V. Wright</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Cheryl Lynn Howard</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3006 Dubois Avenue Parkville, Maryland 21234</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park 9/4/91</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Hank L. Zirckel</b>   |  |   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck Funeral Home Inc. 5305 Harford Road Baltimore, Maryland 21214</b>                           |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA OF THE COLON</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Fausto Q. Aguirre IV MD</b>   |  |   |  |   |  | 29c. LICENSE NUMBER<br><b>D14697</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10-03-91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Fausto Q. Aguirre IV MD 8713 Harford Rd. Baltimore</b>  |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21205-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital for its own use. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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10000 10000 10000

91 23946

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Wilhelmena - GUMMER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 3, 1991</b>  |  | 3. TIME OF DEATH<br><b>1:15 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-01-4259</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 18, 1921</b>                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>                                       |  |
| 10a. STATE<br><b>Md.</b>  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Parkville</b>                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>8301 Wilson Avenue</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21234</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>+</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sr. Engineering Aid</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AAI Corp.</b>                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>-</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>-</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>George C. Gummer</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2513 Moore Avenue Baltimore, Md. 21234</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)<br><b>Garrison Forest Veterans 9/6/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, Md.</b>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James T. Gladden</b>                 |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Left coronary artery cerebral vascular accident probably embolic</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Complete and Permanent Brain Death</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Complete brain death without any spontaneous respiratory effort</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Bradford L. Elbright M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>0202</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/3/91</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Bradford L. Elbright, M.D. 9000 Franklin Square Drive Baltimore MD 21237</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b> REGISTRAR SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23947

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES RIEMAN GRAY</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>August 27, 1991</b>   |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-05-3998</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 10, 1917</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>7343 Yorktowne Drive</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7343 Yorktowne Drive</b>  |  |   |  | 10f. ZIP CODE<br><b>21204</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrical Contractor</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Electrical</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frederick V. Gray</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lula Crossmore</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Virginia Z. Gray</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7343 Yorktowne Drive Towson, Maryland 21204</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Bee Tree Cemetery 8/30</b>                                |  | 20c. LOCATION — City or Town, State<br><b>Parkton, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James F. Burnside, Jr.</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home, Inc.<br/>6500 York Rd. Baltimore, Md. 21212</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASTROCYTOMA (BRAIN)</b>   |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>N. Rosenblum</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D23319</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Nathan Rosenblum, M.D. 6301 N. Charles St. Baltimore, Md. 21212</b>  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Lula Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARC ANTONIO GIACCONI</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>28</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>0247 A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>024-60-2249</b>   |  | 5. SEX<br><b>XXX</b> 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>28</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>5-30-63</b>                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Massachusetts</b>  |  |   |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>SHOCK TRAUMA UNIT</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>             |  |
| 9c. COUNTY OF DEATH<br><b>N/A</b>   |  |   |  | 10. RESIDENCE OF DECEDENT  |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>N/A</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>XXX</b> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4606 Schenley Road</b>   |  |   |  | 10f. ZIP CODE<br><b>21210</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                              |  |
| 11. MARITAL STATUS<br><b>XXX</b> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <b>XXX</b> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <b>XXX</b> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+) <b>3</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Student</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>                             |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Riccardo Giacconi</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mirella Manaira</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Riccardo Giacconi</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>203 Lambeth Road Baltimore, Maryland 21218</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <b>XXX</b> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Crematory</b>        |  | 20c. DATE<br><b>8/30</b>   |  | 20d. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>        |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dennis Stephen Xenakis</b> M00640   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home</b><br><b>6500 York Road Baltimore, Maryland 21212</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Injuries</b>  |  |   |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>XXX</b> YES 2 <input type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <b>XXX</b> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>08 28 1991</b>  |  | 28b. TIME OF INJURY<br><b>1055 A</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES <b>XXX</b> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>DRIVER IN AUTO IMPACT</b>   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>PUBLIC STREET</b>   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>BALTIMORE CITY</b>   |  |   |  | 29a. CERTIFIER<br>(Check only)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <b>XXX</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John Davidson-Randall</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>OCME</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08 28 1991</b>                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. LAKON COCKE MD</b> 111 PENN STREET BALTIMORE, MARYLAND 21201   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><i>Gutman Mollie (MOLLIE GUTMAN)</i>   |  | 2. DATE OF DEATH<br>MONTH <i>8</i> DAY <i>31</i> YEAR <i>91</i>  |  | 3. TIME OF DEATH<br><i>N 50 P M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>212-01-0101</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>84</i> RS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>9-05-06</i>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>MD</i>  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Meridian Nursing Center</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Randallstown</i>   |  | 9c. COUNTY OF DEATH<br><i>Baltimore</i>  |  |
| 10a. STATE<br><i>MARYLAND</i>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>BALTIMORE</i>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>4000 FORDS LA.</i>  |  | 10f. ZIP CODE<br><i>21215</i>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>WHITE</i>   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>CHIEF CLERK</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>EDGEWOOD ARSENAL</i>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>DR. ISADORE GUTMAN</i>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>ESTHER (UNKNOWN)</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>DR. EDWARD GUTMAN</i>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>8700 ALLENSWOOD RD. RANDALLSTOWN, MD 21133</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>BETH EL MEMORIAL PARK</i>   |  | 20c. LOCATION — City or Town, State<br><i>9/3/91 RANDALLSTOWN, MD</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joel D Lewis</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</i>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebral vascular disease multiple CVA</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Claudio Levin</i>  |  | 29c. LICENSE NUMBER<br><i>D27075</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9-1-91</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27, Type, Print)<br><i>CLAUDIO LEVIN 10215 S. Delfield Rd Owings Mills 21117</i>   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 4 1991</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The death certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>SHARMAINE L. HOLLAND (CHARMAQUE)   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 2 1991  |  | 3. TIME OF DEATH<br>11:21 P M   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>7 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>1-31-84  |  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>4131 EIERMAN AVE   |  |  |  | 10f. ZIP CODE<br>21206  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>NEGRO                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CHILD  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>KERRY HOLLAND   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>VERONICA FILLIS  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>VERONICA HOLLAND   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4131 EIERMAN AVE BALTO MD 21206  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT LEON CEM 9/7   |  | 20c. LOCATION — City or Town, State<br>BALTO CO MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Joseph L. Russ  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>VETERANS HOME FID<br>2222 W. NORTH AVE 21216  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. VENTILATORY FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   | Approximate interval Between Onset and Death<br>1 mo |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. CHEMOTHERAPY TOXICITY<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   | 6 mos  |
|  |  | c. ACUTE MYELOCYTIC LEUKEMIA<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   | 7 mos  |
|  |  | d.   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>INFECTION  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Robert S. Greenberg MD, PICU  |  |  |  | 29c. LICENSE NUMBER<br>66895  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/1/91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ROBERT S. GREENBERG MD, PICU, THE JOHNS HOPKINS HOSPITAL, 600 N WOLFE ST. BALTIMORE   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell  |  |   |  |   |  |



91 23951

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FRANCIS J. HUTTON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>1:43 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-38-3375</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS.  |  | 7. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>10</b> YEAR <b>41</b>                                |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>1414 E. Oliver Street</b>  |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 10. COUNTY OF DEATH<br><b>MD</b>   |  |
| 11. RESIDENCE OF DECEDENT<br>10a. STATE <b>MD</b> 10b. COUNTY <b>BALTIMORE</b>   |  |  |  | 12. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  | 13. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 14. STREET AND NUMBER<br><b>1414 E. OLIVER STREET</b>  |  |  |  | 15. ZIP CODE<br><b>21213</b>  |  | 16. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 17. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 20. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |  |
| 21. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>10TH</b>  |  | 22. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>UNEMPLOYED</b>  |  | 23. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 24. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH HUTTON</b>  |  |  |  | 25. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BLANCHE DAVIS</b>   |  |  |  |
| 26. INFORMANT'S NAME (Type/Print)<br><b>HARRY CUSTIS</b>   |  |  |  | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1414 E. OLIVER ST./BALTIMORE, MD 21213</b>   |  |  |  |
| 28. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 29. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place)<br><b>ARBUTUS MEMORIAL PARK</b>   |  | 30. DATE  |  | 31. LOCATION — City or Town, State<br><b>ARBUTUS, MD</b>                                       |  |
| 32. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 33. NAME AND ADDRESS OF FACILITY<br><b>WM.C.MARCH F.H./1101 E. NORTH AVENUE</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acquired Immune Deficiency Syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>INQUIRY</b>  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO               |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>MD</b>   |  |  |  |
| 29c. LICENSE NUMBER<br><b>OCME</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-3-91</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Margarita A. Korell, M.D. 111 Penn Street, Baltimore, MD 21201</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last)  |  | 2. DATE OF DEATH   |  | 3. TIME OF DEATH  |  |
|---|--|--|--|---|--|
| Frank Willie Hall   |  | 08 26 1991   |  | 8:00 AM   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  |
| 249-84-0646   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 43 YRS.   |  |
| 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)   |  | 9. FACILITY NAME (If not institution, give street and number)   |  |
| 7-21-48   |  | S.C.   |  | in water<br>James Run under Rte. 40   |  |
| 10a. STATE  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION   |  |
| MD  |  |  |  | BALTIMORE   |  |
| 10d. INSIDE CITY LIMITS?  |  | 10e. STREET AND NUMBER   |  | 10f. ZIP CODE   |  |
| 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 1735 N. PATTERSON PARK AVENUE  |  | 21213   |  |
| 10g. CITIZEN OF WHAT COUNTRY?   |  | 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |  |
| U.S.A.  |  | 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | BLACK  |  | Elementary/Secondary (0-12)<br>12TH   |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  | 17. FATHER'S NAME (First, Middle, Last)   |  |
| BRICK MAKER   |  | CINDER & CONCRETE BLOCK  |  | SILAS HALL  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  | 19a. INFORMANT'S NAME (Type/Print)   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |
| LUCY JONES  |  | CHARLOTTE HALL   |  | 1735 N. PATTERSON PARK AVE./BALTIMORE, MD 21213   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | 20c. LOCATION — City or Town, State   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | GARRISON FOREST V.A. CEM.  |  | OWINGS MILLS, MD  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  | 22. NAME AND ADDRESS OF FACILITY   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |
|   |  | C. MARCH F.H./1101 E. NORTH AVENUE   |  | IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Drowning</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |
|   |  |  |  | b.<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |
|   |  |  |  | c.<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |
|   |  |  |  | d.<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |
|   |  |  |  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |
|   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)  |  | 27. MANNER OF DEATH   |  |
| HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) in water            |  | 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 08 24 1991  |  | 10:24 AM   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject Drowned  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. CERTIFIER (Check only one)   |  |
| in water  |  | James Run & Route 40   |  | 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)   |  |
| Donald G. Wright MD   |  | O.C.M.E.   |  | 08 26 1991  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  | 31. DATE FILED (Month, Day, Year)  |  | 32. REGISTRAR'S SIGNATURE   |  |
| DONALD G. WRIGHT, MD DCME 111 Penn Street Baltimore Maryland 21201  |  | SEP 4 1991   |  |   |  |

Page 1 of 1



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 91 23953  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|--|--|---|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |   |  |  |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Clara Alverta Hofstetter  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 29, 1991   |  |  |  | 3. TIME OF DEATH<br>3:50 AM   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-03-2459  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (in yrs. last birthday)<br>81 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>09/10/09                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Citizens Nursing Home   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Havre de Grace   |  |  |  | 9c. COUNTY OF DEATH<br>Harford  |  |  |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Harford  |  | 10c. CITY, TOWN OR LOCATION<br>Havre de Grace   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |   |  |
| 10e. STREET AND NUMBER<br>415 S. Market Street  |  |   |  | 10f. ZIP CODE<br>21078  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>6th  |  | College (1-4 or 5+)<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Vernon Kehn  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Clara Bryant   |  |  |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Carolyn Rist  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1516 Baldwin Mill Rd. Jarrettsville, MD 21084  |  |  |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)<br>Metro Crematory, Inc. 8/29                                      |  | DATE<br>8/29  |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD                                 |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>George E. MacNabb  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Cremation Society of Md., Inc.<br>299 Frederick Rd. Balto., MD 21228  |  |  |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. <u>Cardiomyopathy Arter</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Hypertensive Stroke</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>Diarr</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u>None</u> |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><u>None</u>   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Chronic Heart Transplant</u><br><u>Cardiovascular Accident</u>   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                           |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                 |  |  |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>N/A   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>N/A   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>MD   |  | 29c. LICENSE NUMBER<br>D19583  |  | 29d. DATE SIGNED (Month, Day, Year)<br>08/29/91 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Manuel M. Lazatin, M.D. 8 Law Street Aberdeen, MD 21001  |  |   |  |   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |   |  |  |  |   |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23954

|   |  |  |                                 |   |      |   |   |  |   |   |  |
|---|--|--|---------------------------------|---|------|---|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALMA HARTLOVE</b>  |  |  |                                 | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>3</b> YEAR <b>91</b>  |      | 3. TIME OF DEATH<br>M                                   |   |  |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-364775</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |                                 | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |      | 7. DATE OF BIRTH<br>(Month/Day/Year)<br><b>11/13/17</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>                                      |   |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST JOSEPH HOSPITAL 1205 York Rd</b>  |  |  |                                 | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson MD 21204</b>   |      |   |   | 9c. COUNTY OF DEATH<br><b>BALT</b>   |   |   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  | 10b. COUNTY<br><b>Baltimore</b> |   |      | 10c. CITY, TOWN OR LOCATION<br><b>Parkville</b>         |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>2802 Summit Avenue</b>   |  |  |                                 |   |      | 10f. ZIP CODE<br><b>21234</b>                           |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                      |   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                 | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |      |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>2</b>   |  |  |                                 | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nurse - Ret.</b>  |      |   | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ferdinand Litke</b>   |  |  |                                 | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Bloch</b>  |      |   |   |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles L. Hartlove Jr.</b>  |  |  |                                 | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2802 Summit Ave. Baltimore, Md. 21234</b>   |      |   |   |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery 9/6/91</b>                           |                                 |   | DATE |   | 20c. LOCATION — City or Town, State<br><b>Baltimore Maryland</b>        |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Milton J Knight Jr</b>  |  |  |                                 | 22. NAME AND ADDRESS OF FACILITY<br><b>Baltimore, Md. 21214<br/>Leonard J. Ruck, Inc. 5305 Harford Road</b>   |      |   |   |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE ORGAN FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |                                 |   |      |   |   | Approximate Interval Between Onset and Death   |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                                 |   |      |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |                                 | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |      |   |   |  |   |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide<br><input type="checkbox"/> Could not be determined  |  |  |                                 | 28a. DATE OF INJURY<br>(Month, Day, Year)   |      | 28b. TIME OF INJURY<br>M                                |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO           |   | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
|   |  |  |                                 | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |      |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)               |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |                                 |   |      |   |   |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Henry Chiu</b>  |  |  |                                 |   |      |   |   | 29c. LICENSE NUMBER<br><b>D26054</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br>▶  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PERY CHHIM, M.D. House officer at Saint Joseph Hospital</b>   |  |  |                                 |   |      |   |   |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  |  |                                 | 32. REGISTRAR'S SIGNATURE<br><b>John Switzer-Randall</b>  |      |   |   |  |   |   |  |

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91 23955

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ETHEL HUTCHINSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>30</b> YEAR <b>1991</b>  |  |   |  | 3. TIME OF DEATH<br><b>8:00 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-01-8410</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10/3/19</b>                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>BALTIMORE, MD</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>3202 Rosekemp Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21214</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Secretary</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Meat Packing Co.</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Albert Frick</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ethel Inwald</b>  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Harry E. Hutchinson</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3202 Rosekemp Avenue Baltimore, Md. 21214</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Mem. Sept. 3, 1919</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>                                |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James T. Bladden</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>DEHYDRATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <b>METASTATIC CANCER OF PANCREAS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. <b>LEG CELLULITIS AND SEPSIS, UTI</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><b>3 years</b>                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>LEG CELLULITIS AND SEPSIS, UTI</b>  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J.C. Downs MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>033627</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/3/91</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J.C. Downs MD O'Dea Building 7505 Osler Drive Suite 504 Towson, Md. 21204</b>  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23956

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen Marie Humphreys</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 1 1991</b>                                       |  | 3. TIME OF DEATH<br><b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-74-3881</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 2, 1902</b>                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>PA</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1000 Franklin Ave<br/>Lauenstein Building Apt. 405</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br><b>1000 Franklin Ave. Apt. 405</b>  |  |  |  | 10f. ZIP CODE<br><b>21221</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>6th</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas B. Lewis</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Helen Hoon</b>  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ray Humphreys</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>418 Harbour Drive Ocean City Maryland 21842</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Belair Memorial 9/5/91</b>   |  | 20c. LOCATION — City or Town, State<br><b>Belair Maryland</b>   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Connelly Funeral Home</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home 300 Mace Ave. 21221</b>  |  |   |  |   |  |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CVA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p>a. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF): <b>HT CVD</b></p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p> </div> </div> |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|   |  |  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Marvin Rombro</i>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-2-91</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Marvin Rombro 805 Fuselage Ave 21220</b>  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2007-10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE                    |  |   |  | 91 23957   |  |
|---|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CORR E. JOHNSON   |  |  |  | 2. DATE OF DEATH<br>SEPTEMBER 1, 1991   |  | 3. TIME OF DEATH<br>11:30pm  |  |
| 4. SOCIAL SECURITY NUMBER<br>217-20-4253  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>99 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>10-25-1891  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY  |  | 10. COUNTY OF DEATH<br>BALTIMORE CITY  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>MARYLAND GENERAL HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY   |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY  |  |
| RESIDENCE OF DECEDENT   |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY<br>Balto.  |  |
| 10c. CITY, TOWN OR LOCATION<br>Balto.   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>3407 Dennlyn Rd.   |  |
| 10f. ZIP CODE<br>21215  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Jones  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Gertrude Ford  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Lishia Johnson   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3407 Dennlyn Rd. Balto., Md. 21215   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Baltimore Cemetery 9/6   |  | 20c. LOCATION — City or Town, State<br>Balto., Md.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Joseph L. Russ   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Joseph L. Russ, F.H.<br>2222 W. North Ave. Balto., Md. 21216  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>PNEUMONIA   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/2/91  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>WISSAM CHATILA, M.D. c/o MARYLAND GENERAL HOSPITAL   |  |  |  | 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |  |   |  |  |  |

17003 12

91 23958

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>George A. Jackson</u>  |  |   |  | 2. DATE OF DEATH<br>MONTH <u>8</u> DAY <u>31</u> YEAR <u>1991</u>   |  | 3. TIME OF DEATH<br><u>3:55 A M</u>   |   |
| 4. SOCIAL SECURITY NUMBER<br><u>217 16 4020</u>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><u>68</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>09-04-1923</u>                         |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>BALTIMORE, MD.</u>   |  |   |  |   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>LOCH RAVEN VA.</u>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>BALTIMORE</u>   |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br><u>MD.</u>  |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><u>BALTIMORE</u>                                     |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |   |   |
| 10e. STREET AND NUMBER<br><u>2516 WEST FAIRMOUNT AVENUE</u>   |  |   |  | 10f. ZIP CODE<br><u>21223</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>BLACK</u>          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>FORK LIFT OPERATOR</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>ARMY DEPOT</u>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>JOHN JACKSON</u>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>MARIE MICKENS</u>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>CATHERINE JACKSON</u>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2516 WEST FAIRMOUNT AVENUE BALTO. MD. 21223</u>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>GARRISON FOREST VA.</u>  |  | 20c. LOCATION — City or Town, State<br><u>OWINGS MILLS, MD.</u>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>[Signature]</u>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><u>L.H. Brown Jr. F/H 1915 W. Balto St</u><br><u>P.O. BOX 4433 21223</u>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <u>CVA</u><br>b. <u>Decubid ulcer</u><br>c. <u>Renal Insufficiency</u><br>d. <u>Renal Insufficiency</u> |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension</u><br><u>Diabetes</u><br><u>Congestive heart failure</u>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <u>BALTIMORE, VA.</u>   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Trevor A. Litchner MD.</u>  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>8/31/91</u>                               |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Trevor A. Litchner MD. BALT. VAH, 3900 Loch Raven Blvd</u>  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 4 1991</u>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital, attending physician, or funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23959

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DOROTHY K. JESKEY  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPT 2 1991   |  | 3. TIME OF DEATH<br>0430 M   |   |
| 4. SOCIAL SECURITY NUMBER<br>216-34-6417   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>73 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>APRIL 4 1918                                  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>MD.  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>6833 Queens Ferry Road  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  | 9c. COUNTY OF DEATH<br>Baltimore   |   |
| RESIDENCE OF DECEDENT  |  |   |  | 10a. STATE<br>MD.   |  | 10b. COUNTY<br>BALTIMORE   |   |
| 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |   |
| 10e. STREET AND NUMBER<br>6833 Queens Ferry Road   |  |   |  | 10f. ZIP CODE<br>21239  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) N/A<br>College (1-4 or 6+) N/A   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Seamstress   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Sewing Factory  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Jeskey   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Baron   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Rose L. Kilmon (dghtr)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6833 Queens Ferry Rd., Baltimore, Md. 21239  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>METRO CREMATORY INC.   |  | DATE  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE MD.                                 |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>SCHIMUNEK FUNERAL HOME INC.<br>3331 Brehms Lane, Baltimore, Md. 21213   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Brain ischemia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Cardiac shock<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Ali H. Youssoufi  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/2/91  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ali H. Youssoufi The Good Samaritan Hosp. of Maryland.  |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991  |  | 32. REGISTRAR'S SIGNATURE<br>Gina Davidson-Randall  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23960

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CLARA JULIA JONES   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>8 30 91   |  | 3. TIME OF DEATH<br>10 <sup>55</sup> A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-20-2288  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>81 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>FEB. 18, 1910   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>HARBOUR HOSPITAL  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br>MARYLAND  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>1150 W. HAMBURG STREET  |  |  |  | 10f. ZIP CODE<br>21230  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7TH GRADE<br>College (1-4 or 8+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>DIETARY WORKER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>HOSPITAL   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOSEPH GUTKOSKA  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>SARAH CALLAWAY   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>SARAH E. HAYES  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1150 W. HAMBURG STREET, BALTIMORE, MD. 21230   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>NEW CATHEDRAL CEMETERY   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HUBBARD FUNERAL HOME INC.<br>4107 WILKENS AVENUE, BALTIMORE, MD. 21229  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. END STAGE CARDIAC DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CHRONIC RENAL INSUFFICIENCY<br>ATHEROSCLEROTIC CORONARY VASCULAR DISEASE<br>CHRONIC OBSTRUCTIVE PULMONARY DISEASE   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>David Woodruff, MD   |  |  |  | 29c. LICENSE NUMBER<br>A52441614-35   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8-30-91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>David Woodruff, Harbor Hospital 3000 S. Hanover St BALTO, 21230  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julian Davidson-Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial and permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23961

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>JOANN VIRGINIA JOHNSON   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>8-23-91  |  | 3. TIME OF DEATH<br>5:35P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-12-9908   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>10-31-15                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Delaware   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Meridian Long Green  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                     |  |
| 9c. COUNTY OF DEATH<br>N/A   |  |  |  | 10a. STATE<br>Maryland   |  |  |  |
| 10b. COUNTY<br>Harford   |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Jarrettsville   |  |  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>3608 Woodholme Drive   |  |  |  |
| 10f. ZIP CODE<br>21084   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 11 College (1-4 or 5+) 11  |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>LPN   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Private Duty   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Terrence L. Daley  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3608 Woodholme Dr. Jarrettsville Maryland 21084   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Grace Lawn Memorial Cem.  |  | 20c. LOCATION — City or Town, State<br>Wilmington, Delaware  |  | 21. SIGNATURE OF FUNERAL SERVICE EMPLOYEE<br>Dennis Stephen Xenakis                  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home<br>6500 York Road Baltimore, Maryland 21212  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. ASCVD<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEIZURE disorder<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Seizure disorder |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>XX YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>XX YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dr. Robert Vissing  |  |  |  | 29c. LICENSE NUMBER<br>D33597  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/26/91                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Robert Vissing 4300 North Charles St. Baltimore, Maryland 21218   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 23962

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Joseph D. Kuzyk</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>28</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>7:30 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-28-3078</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1/17/18</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Joseph Richey Hospice</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO.</b>   |  |
| 9c. COUNTY OF DEATH<br><b>MD</b>   |  |  |  | 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>2114 Fleet Street</b>   |  |
| 10f. ZIP CODE<br><b>21231</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12th grade</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>GROGER</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RETAIL FOOD</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Samuel KUZYK</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AGNES ZACHARKO</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>George KUZYK</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>811 Peppard Dr. Bel Air, Md 21014</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Stanislaus Cem. Baltimore Md</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Baltimore Md</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>David J. Weber</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>401 S. Chester Edward J. Weber F.H. Baltimore, Md 21231</b>   |  |  |  | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of lung with mets</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>On hospice</b><br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |  |  |
| 29c. LICENSE NUMBER<br><b>D-14221</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8.30.91</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>T. A. Brown 223 B Blvd Balt up 21221</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained for hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23963

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |  |   |   |  |   |  |
|---|--|--|--|--|--|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>KOON WO LEE   |  |  |  | 2. DATE OF DEATH<br>MONTH: SEPT. 3 1991 YEAR   |  |   |  | 3. TIME OF DEATH<br>5:15 A M   |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-62-7241  |  |  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>APRIL 20, 1908                             |   | 8. BIRTHPLACE (State or Foreign Country)<br>CHINA   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FALLSTON GENERAL HOSPITAL   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FALLSTON   |  |  | 9c. COUNTY OF DEATH<br>HARFORD  |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |  |   |   |  |   |  |
| 10a. STATE<br>MARYLAND  |  |  | 10b. COUNTY<br>HARFORD   |  |  | 10c. CITY, TOWN OR LOCATION<br>BEL AIR  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |   |  |
| 10e. STREET AND NUMBER<br>700 PONDEROSA COURT   |  |  |  |  |  | 10f. ZIP CODE<br>21014  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>ORIENTAL                            |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA College (1-4 or 5+) NA   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CHEF  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>RESTAURANT   |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>UNKNOWN  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>UNKNOWN  |  |  |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>KENT SHING LEE (SON)  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>700 PONDEROSA COURT, BEL AIR, MD 21014   |  |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>LORRAINE PARK CEMETERY  |  |   |  | DATE   |   | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Eugene J. Lastnig</i>   |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SCHIMUNEK FUNERAL HOMES, INC.<br>9705 BELAIR ROAD, BALTIMORE, MD 21236  |  |  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br><i>10 days</i>  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William M.D.</i>  |  |  |  |  |  | 29c. LICENSE NUMBER<br><i>D32609</i>  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9.3.91</i>  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |  |  |   |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>  |  |   |  |  |   |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23964

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ROSINA M. LIVINGSTON   |  | 2. DATE OF DEATH<br>MONTH 9 DAY 3 YEAR 91  |  | 3. TIME OF DEATH<br>1:25 P.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>215-01-9372   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>91 YRS.   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br>APR. 4, 1900   |  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>ST. AGNES HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |
| 10e. STREET AND NUMBER<br>769 S. WOODINGTON ROAD   |  | 10f. ZIP CODE<br>21229   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7TH GRADE<br>College (1-4 or 5+) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>FLOOR SUPERVISOR   |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br>CANDY MANUFACTURING  |  | 17. FATHER'S NAME (First, Middle, Last)<br>JACOB M. DILLMAN  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARY M. DWYER  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>LORRAINE FOSBRINK  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>769 S. WOODINGTON ROAD, BALTIMORE, MD. 21229  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MOST HOLY REDEEMER CEMETERY 9/6   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  | 22. NAME AND ADDRESS OF FACILITY<br>HUBBARD FUNERAL HOME INC.<br>4107 WILKENS AVENUE, BALTIMORE, MD. 21229   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. CONGESTIVE HEART FAILURE  |  | Approximate interval Between Onset and Death<br>WEEKS   |  |
|  |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  |
|  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>CARMINIA E. DAVIDSON, MD  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br>SEPT 3, 1991   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CARMINIA E. DAVIDSON, MD ST. AGNES HOSPITAL, 900 CATON AVE, BALTIMORE, MD 21229   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

12555 10



91 23965

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CLARA LANG  |  |   |  | 2. DATE OF DEATH<br>MONTH 8 DAY 28 YEAR 91  |  | 3. TIME OF DEATH<br>9:47A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-36-9272  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>91 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12-8-99  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>N/A  |  |
| 10a. STATE<br>Maryland  |  |   |  | 10b. COUNTY<br>N/A  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>830 W/40th St.  |  |   |  | 10f. ZIP CODE<br>21211  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Anne Arundel County   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph Rieder  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Carris Mehrer  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Richard H. Lang   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>827 Branford Circle Lutherville, Maryland 21093  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Druid Ridge   |  | 20c. LOCATION — City or Town, State<br>Pikesville, Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Dennis Stephen Xenakis</i><br>Dennis Stephen Xenakis  |  | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home<br>6500 York Road Baltimore, Maryland 21212   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>ASPIRATION</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>SEIZURE</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |  | Approximate Interval Between Onset and Death<br><i>immediate</i><br><i>immediate</i><br><i>10m</i>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Davidson-Randall</i>   |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/29/91  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALEX McCARGO</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>26</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>2:02 P M</b>   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216083042</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-28-38</b>                                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>4718 PARK HEIGHTS AVENUE</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  |   |  | 9c. COUNTY OF DEATH   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br><b>4718 PARK HEIGHTS AVE</b>  |  |  |  | 10f. ZIP CODE<br><b>21215</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |   |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b> |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>DISABILITY</b>              |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FREDIE McCARGO</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ALFASCE RICHARDSON</b>   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>EMMA BOYD</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4718 PARK HEIGHTS AVE BALTO MD 21215</b>   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT ZION CHURCH</b>                                     |  | OATE<br><b>91</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO CG MD</b>                                   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. Russ F.H.<br/>2322 W. North Ave. Balto, Md 21216</b>  |  |   |  |   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic alcoholism</b> |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                          |  | OTHER:<br><input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Donald G. Wright MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/27/91</b>                                      |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DONALD G. WRIGHT MD DCME 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>   |  |  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia [Signature]</b>  |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |      |  |  |   |   |   |
|---|--|--|--|---|------|--|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BERNARD INGRAM MAYES</b>   |  |  |  |   |      | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>22</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>1:45 PM</b>  |   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>242-86-5468</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>37</b> YRS.  |      | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3-15-54</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>   |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mercy Hospital</b>   |  |  |  |   |      | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  | 9c. COUNTY OF DEATH<br><b>na</b>  |   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>na</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |      |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |   |
| 10e. STREET AND NUMBER<br><b>116 PORT STREET</b>  |  |  |  | 10f. ZIP CODE<br><b>21224</b>   |      | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |   |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |      |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b> |   |   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>College</b>  |  |  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>  |      |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Luther Ingram</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annabelle Ingram</b>  |      |  |  |   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Annabelle Mayes</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20 Hazzard St./Ashville, N.C.</b>   |      |  |  |   |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Voshell Mem. Gardens</b>                               |  |   | DATE |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>               |   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY:<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE</b>  |      |  |  |   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE NARCOITIC INTOXICATION</b><br><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |  |  |   |      |  |  |   | Approximate Interval Between Onset and Death  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |      |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA               |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                              |      |  |  |   |   |   |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input checked="" type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>FOUND: 8-22-91</b>  |  | 28b. TIME OF INJURY<br><b>UNKNOWN</b>   |      | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                        |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>UNKNOWN</b>   |   |   |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND IN APARTMENT</b>                          |  |   |      | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>514 CATHEDRAL ST BALTO., MD</b> |  |   |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |      |  |  |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Mario F. Golle Jr. M.D.</b>   |  |  |  |   |      | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>August 23, 1991</b>                                   |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mario F. Golle Jr. M.D. 111 Penn St. Baltimore, Md. 21201</b>   |  |  |  |   |      |  |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |      |  |  |   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>REGINA C. McNAMARA</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPT. 3, 1991</b>  |  | 3. TIME OF DEATH<br><b>3:40 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-07-4738</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MARCH 25, 1922</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>1946 SIDNEE AVENUE</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>EDGEWOOD</b>   |  |
| 9c. COUNTY OF DEATH<br><b>HARFORD</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>HARFORD</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>EDGEWOOD</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1946 SIDNEE AVENUE</b>  |  |
| 10f. ZIP CODE<br><b>21040</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>NA</b> College (1-4 or 5+) <b>NA</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN W. HAYWARD</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY HASKELL</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROBERT McNAMARA (SON)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>34 PINEY RIDGE LANE, NORTH EAST, MD 21901</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Eugene J. Laster</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOMES, INC.<br/>9705 BELAIR ROAD, BALTIMORE, MD 21236</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Colon Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael Auerbach</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>033551</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/3/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. MICHAEL AUERBACH, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23970

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |   |  |   |   |   |  |
|--|--|--|---|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Faye L. Maguire</b>   |  |  |   | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>2</b> YEAR <b>91</b>   |  |   |  | 3. TIME OF DEATH<br><b>10:45 a.m.</b>   |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>249-01-5050</b>  |  |  |   | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>03/02/16</b>                                   |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>  |  |  |   |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |   |   | 9c. COUNTY OF DEATH<br><b>---</b>                                 |  |
| RESIDENCE OF DECEDENT  |  |  |   |  |  |   |  |   |   |   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>   |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>312 Montrose Avenue</b>   |  |  |   |  |  | 10f. ZIP CODE<br><b>21228</b>   |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>  |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Business Owner</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Forest Haven Nursing Home</b>                          |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joshua Lowe</b>  |  |  |   |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bertha Payne</b>  |  |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William R. Monroe</b>   |  |  |   |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>312 Montrose Avenue Catonsville, MD 21228</b>   |  |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lorraine PK Mausoleum 9/5</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Woodlawn, MD</b>                                  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>  |  |  |   |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MacNabb Funeral Home, P.A.<br/>301 Frederick Rd. Baltimore, MD 21228</b>   |  |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |   |  |  |   |  |   |   |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |   |  |  |   |  |   |   |   |  |
| a. <b>Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):   |  |  |   |  |  |   |  |   |   |   |  |
| b. <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF):   |  |  |   |  |  |   |  |   |   |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |  |  |   |  |   |   |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |  |  |   |  |   |   |   |  |
| Approximate Interval Between Onset and Death<br><b>4 days</b><br><b>13 days</b>  |  |  |   |  |  |   |  |   |   |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |   |  |  |   |  |   |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |   |  |   |   |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |   |  |  |   |  |   |   |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |   |  |  |   |  |   |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |   | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                                 |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |  |  |   |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Jeffrey F. Cole, MD</b>  |  |  |   |  |  | 29c. LICENSE NUMBER<br><b>021512</b>  |  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/2/91</b>  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jeffrey F. Cole, MD 3455 Wilkens Avenue Balt MD 21229</b>  |  |  |   |  |  |   |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |   | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Audrey H. Merendino</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>8</u> DAY <u>29</u> YEAR <u>91</u>   |  | 3. TIME OF DEATH<br><u>12:30</u> A M  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>212-50-3808</u>  |  | 5. SEX<br><u>1</u> <input type="checkbox"/> M <u>2</u> <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>73</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>03-27-18</u>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>ST. JOSEPH HOSPITAL</u>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>TOWSON, M.D.</u>  |  | 9c. COUNTY OF DEATH<br><u>BALTIMORE</u>   |  |
| 10a. STATE<br><u>Maryland</u>  |  | 10b. COUNTY<br><u>Baltimore</u>  |  | 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><u>7118 Greenwood Avenue</u>   |  |  |  | 10f. ZIP CODE<br><u>21206</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u><br><u>8th Grade</u>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Waitress</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Merendino's</u>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>James Cornwell</u>   |  |  |  | 15. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>May Plowman</u>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Joseph S. Merendino</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7118 Greenwood Avenue, Baltimore, Maryland 21206</u>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Gardens of Faith</u>   |  | DATE<br><u>8/31</u>   |  | 20c. LOCATION — City or Town, State<br><u>Baltimore, Maryland</u>                               |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Kathleen M. Murphy</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>John C. Miller, Inc.</u><br><u>6415 Belair Road, Baltimore, Maryland 21206</u>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <u>Metastatic Breast Carcinoma</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Marked Dehydration</u><br><u>Diabetes Mellitus</u> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><u>36 hrs</u><br><br><u>years</u>               |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Richard D. Patten MD</u>   |  |  |  | 29c. LICENSE NUMBER<br><u>D39609</u>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>8/29/91</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>R. Patten MD</u> <u>7120 York Road</u> <u>Baltimore, Towson 21204</u> <u>(St. Joseph's Hosp)</u>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 4 1991</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Donald K. Markle</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 27 1991</b>  |  | 3. TIME OF DEATH<br><b>5:20 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-60-0917</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>37</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 30, 1954</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>835 Bonifant</b>  |  |
| 10f. ZIP CODE<br><b>20910</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>11/15/71 11/28/73</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b><br><b>College (1-4 or 5+) N/A</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>N/A</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Donald A. Markle</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Wilma E. Day</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Wilma E. Markle</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>246 Maple Avenue Keyser, WV 26726</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Potomac Memorial Gardens August 31 1991</b>  |  | 20c. LOCATION — City or Town, State<br><b>Keyser, WV 26726</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rotruck Funeral Home</b><br><b>85 South Main Street Keyser, WV 26726</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Injuries</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>08 27 1991</b>  |  | 28b. TIME OF INJURY<br><b>5:20 AM</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject struck by auto</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>On street</b>   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>8100 blk. Fenton Street</b>  |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08 28 1991</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. Laron Locke, MD 111 Penn Street, Baltimore Maryland 21201</b>  |  |  |  |  |  |  |  |
| 31. DATE OF DEATH (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STORY 15

... 2. 1.

... 2. 1.

91 23973

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Roberta O. McGee</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>8 31 91</i>   |  | 3. TIME OF DEATH<br><i>6:14 P M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>214-20-1894</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>76</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>10-12-1914</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>MD</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Mercy Medical Center</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Balto</i>  |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>703 N. Rosedale St.</i>   |  |
| 10f. ZIP CODE<br><i>21216</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>10th</i> College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Chapman Morris</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Eleanor Travis</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>John Morris</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>261 N. Bruce St. Balto. Md.</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Baltimore Cemetery 9-6-91 Balto. Md.</i>   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Wynne B. Scott</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>March F/H-West Balto. Md. 21215</i>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. metastatic oat cell CA of lung / to liver</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>b. DUE TO (OR AS A CONSEQUENCE OF):</i><br><i>c. DUE TO (OR AS A CONSEQUENCE OF):</i><br><i>d. DUE TO (OR AS A CONSEQUENCE OF):</i> |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>gastrointestinal bleeding</i><br><i>diabetes mellitus</i><br><i>urinary tract infection</i>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John F. Wiley MD</i>   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>8/31/91</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>John Wiley 80 Mercy 301st Paul Pl, Balt. MD 21202</i>  |  |  |  |  |  |  |  |
| 31. DATE (Month, Day, Year)<br><i>SEP 4 1991</i>   |  |  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23974

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |                                |  |   |   |  |
|--|--|--|---|---|--------------------------------|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Gennie</b>  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 1, 1991</b>  |                                |  |   | 3. TIME OF DEATH<br><b>6:20 P</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-16-5073</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10-22-02</b>                        |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Italy</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>   |                                |  | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>                          |   |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |                                |  |   |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |   | 10c. CITY, TOWN OR LOCATION<br><b>Rosedale</b>  |                                |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>5813 Comstock Ave.</b>  |  |  |   | 10f. ZIP CODE<br><b>21206</b>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b> |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>7</b>  |  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>homemaker</b> |   |                                | 16b. KIND OF BUSINESS/INDUSTRY   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Anthony Cannavo</b>  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Petronella Cannavo</b>  |                                |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lucia Marrocco</b>  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3905 Eland Rd.; Phoenix, MD 21131</b>   |                                |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith</b>   |   |   | DATE                           |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>             |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br><b>Cvach/Rosedale Funeral Home</b><br><b>1211 Chesaco Ave.</b>  |                                |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Bilateral Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Pneumothorax</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Arteriosclerotic Coronary Artery Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |  |   |   |                                |  |   | Approximate interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |   |                                |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |   |   |                                |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |                                |  |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br><b>M</b>   |                                | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |                                |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Aaron Green MD</b>   |  |  |   |   |                                | 29c. LICENSE NUMBER  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/1/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Aaron Green, M.D. 9000 Franklin Square Drive Baltimore, MD. 21237</b>  |  |  |   |   |                                |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |   | 32. REGISTRAR'S SIGNATURE<br>   |                                |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23975

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GERTRUDE L. NELSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>29</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>1:15 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-18-3212</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07-04-12</b>                                      |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSP. OF BALTIMORE</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 8c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| 9a. STATE<br><b>MD</b>   |  |  |  | 9b. COUNTY<br><b>BALTIMORE</b>  |  | 9c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |
| 10a. STREET AND NUMBER<br><b>4004 BELVEDERE AVE</b>  |  |  |  | 10b. ZIP CODE<br><b>21215</b>   |  | 10c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES       |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>NEGED</b>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEMAKER</b>                 |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EDDIE BRYANT</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LILLIAN BRYANT</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type, Print)<br><b>ALFRED WASHINGTON</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4765 CHATFORD AVE BALTO MD 21206</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>KING MEM PARK</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO MD</b>  |  | 20d. DATE<br><b>9-3-91</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH L. RUSS F.L.T.</b><br><b>2222 W. NORTH AVE BALTO MD 21216</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOPULM. ARREST</b>  |  |  |  |   |  |   |  |
| Due to (or as a consequence of):   |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| Due to (or as a consequence of): <b>ACUTE RENAL INSUFFICIENCY</b>  |  |  |  |   |  |   |  |
| Due to (or as a consequence of): <b>ANGIOGRAM</b>  |  |  |  |   |  |   |  |
| Due to (or as a consequence of):   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>- ICDM</b><br><b>- CHF.</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one) <b>SINAI HOSP.</b>   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>House OFFICER</b>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08/29/91</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. M. A. MATH MOND, SINAI HOSPITAL, BELVEDERE AVE, BALTO. 21215 MD</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>08/29/91</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |   |  |  |  |
|---|--|---|--|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RHODA L. NOLDER / Rhoda Lavina Nolder</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>29</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>11:25 P M</b>  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-38-4638</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>06/06/06</b>                                      |   |  |  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |   |  |  |  |   |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  | 9c. COUNTY OF DEATH<br><b>---</b>   |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Lutherville</b>   |   |  |  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |  |  |   |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>908 Morris Avenue</b>  |  |   |  | 10f. ZIP CODE<br><b>21093</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 8+) <b>College</b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Crawford Fryer</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Bell Patterson</b>  |  |   |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>H. Lloyd Nolder</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2518 Glencoe Rd. Baltimore, MD 21234</b>   |  |   |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 8/30</b>                            |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>  |  |   |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Md., Inc.<br/>299 Frederick Road Balto., MD 21228</b>  |  |   |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiac shock</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>acute mitral regurgitation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>acute myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HP @ Total Hip Replacement</b> |  |   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>ALA</b>  |  | 28b. TIME OF INJURY<br><b>AA</b> M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>NA</b>  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>NA</b>  |  |   |   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>NA</b>   |  |   |  |  |  |   |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>B. Husted MD</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>Med House Officer</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8-30-91</b>                                       |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Berit M. Husted Union Memorial Hosp 201 E. Univ. Parkway</b>  |  |   |  |  |  |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Johia Davidson-Randall</b>   |  |   |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>Franklin Benjamin Owens</b><br><b>FRANKLIN BENJAMIN OWENS</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>18:40</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-07-4755</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>07/26/17</b>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>---</b>   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>710 Eastshire Drive</b>  |  |   |  | 10f. ZIP CODE<br><b>21228</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>---</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Security Supervisor</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Giant Foods</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Adam Owens</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Selma E. Eversmeier</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Judith Atkinson</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>632 Freeland Rd. Freeland, MD 21053</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crestlawn Mem. Grdns 9/3</b>  |  | 20c. LOCATION — City or Town, State<br><b>Marriottsville, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MacNabb Funeral Home, P.A.<br/>301 Frederick Rd. Balto., MD 21228</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. <b>PULMONARY EMBOLISM</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. <b>DEEP VEIN THROMBOSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|   |  | c. <b>METASTATIC CA</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
|   |  | d. <b>RENAL FAILURE</b>   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kirk Atkinson</b>   |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KRAIRERK ATHIRAKUL M.D., ST. AGNES HOSPITAL BALTIMORE MD 21229</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1947

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LEO BERT ORVIS</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 30, 1991</b>  |  |   |  | 3. TIME OF DEATH<br><b>9:05 A.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>367 22 8164</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (in yrs. last birthday)<br><b>65 YRS.</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>11-1-25</b>                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MICHIGAN</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>VA MEDICAL CENTER</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FORT HOWARD</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>4411 RASPE AVENUE</b>   |  |   |  | 10f. ZIP CODE<br><b>21206</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>11-3-48 8-13-52</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>PRINTER</b>   |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>PRINTER</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Bert Orvis</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Dora Cotton</b>   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CLINICAL RECORDS, VAMC</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9600 NORTH POINT ROAD FORT HOWARD, MD 21052</b>   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cem.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Balto., Md.</b>   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John C. Miller Inc.<br/>6415 Belair Rd. Balto., Md. 21206</b>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PNEUMONIA</b>   |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |
| 29c. LICENSE NUMBER  |  |   |  |   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>AUGUST 30, 1991</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>C.V.J. VERGHESE, M.D. 9600 NORTH POINT ROAD FORT HOWARD, MARYLAND 21052</b>  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 23979

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
|---|---|---|--|--|--|---|----------------------------------|--|----|---|---------------|----|----------------------------------|---------------|----|----------------------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EARL PURVIS EARL (LORENZO) PURVIS</b>  |   |   |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>21</b> YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>8:30 AM</b>  |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-34-0423</b>   |   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>54</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>5-21-37</b>  |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>JOHN DEATON N.H.</b>   |   |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  | 8c. COUNTY OF DEATH   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| RESIDENCE OF DECEDENT   |   |   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 10a. STATE<br><b>MD</b>   |   | 10b. COUNTY   |  | 10e. STREET AND NUMBER<br><b>5565 WHITBY ROAD</b>  |  | 10f. ZIP CODE<br><b>21206</b>   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12TH</b>   |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LAB WORKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>JOHN HOPKINS UNIVERSITY</b>   |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM PURVIS</b>  |   |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MABEL WHITLEY</b>  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DOROTHY E. PURVIS</b>  |   |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5565 WHITBY RD./BALTIMORE, MD 21206</b>  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Calvin L. Williams</i>  |   |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C.MARCH F.H./1101 E. NORTH AVENUE</b>  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><table border="0"> <tr> <td>a.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td>Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td><b>ASPIRATION PNEUMONIA</b><br/>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>2 DAYS</b></td> </tr> <tr> <td>c.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td><b>2 DAYS</b></td> </tr> <tr> <td>d.</td> <td>DUE TO (OR AS A CONSEQUENCE OF):</td> <td></td> </tr> </table> |   |   |  |  |  | a.  | DUE TO (OR AS A CONSEQUENCE OF): | Approximate Interval Between Onset and Death | b. | <b>ASPIRATION PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF): | <b>2 DAYS</b> | c. | DUE TO (OR AS A CONSEQUENCE OF): | <b>2 DAYS</b> | d. | DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |
| a.  | DUE TO (OR AS A CONSEQUENCE OF):                                | Approximate Interval Between Onset and Death  |  |  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| b.  | <b>ASPIRATION PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF): | <b>2 DAYS</b>   |  |  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| c.  | DUE TO (OR AS A CONSEQUENCE OF):                                | <b>2 DAYS</b>   |  |  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| d.  | DUE TO (OR AS A CONSEQUENCE OF):                                |   |  |  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>POTENTIAL CEREBROVASCULAR ACCIDENT</b>   |   |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
|   |   |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
|   |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James P. Richardson MD</i>  |   |   |  | 29c. LICENSE NUMBER<br><b>027394</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/21/91</b>   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>611 S. CHARLES ST. BALTO. MD 21230 (JAMES P. RICHARDSON MD)</b>   |   |   |  |  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |   | 32. REGISTRAR'S SIGNATURE<br><i>Gina Davidson-Randall</i>   |  |  |  |   |                                  |  |    |   |               |    |                                  |               |    |                                  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial final plan. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 23980

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><i>Elizabeth C. Poehler</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>4</i> YEAR <i>91</i>  |  | 3. TIME OF DEATH<br><i>6 A M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>220-14-7858</i>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>80</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>12-14-1911</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Francis Scott Key Medical Center</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore City</i>  |  |
| 9c. COUNTY OF DEATH   |  |  |  |   |  |   |  |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore City</i>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>512 South Streeper Street</i>  |  |  |  | 10f. ZIP CODE<br><i>21224</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>United States</i>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                          |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i><br><i>8</i>   |  | 16. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Housewife</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>William L. Denver, Sr.</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Veronica</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Peter Denver</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>310 Sharon Drive Pasadena, MD 21122</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Oak Lawn Cemetery 9/7/91</i>   |  | 20c. LOCATION — City or Town, State<br><i>Baltimore, MD</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Elizabeth A. Selinski</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Lilly &amp; Zeiler, Inc. Funeral Homes<br/>700 S. Conkling Street Balto., MD 21224</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Aspiration Pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <i>Cerebrovascular accident</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Dementia</i> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><i>hours</i><br><i>years</i>                        |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  | 28. DATE OF INJURY (Month, Day, Year)   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John R. Burton MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>001889</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9-4-91</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>John R. Burton 5505 Bayview Circle Balto 21224</i>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 4 1991</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John R. Burton</i>  |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0620  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

27-38-11

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for the funeral-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 91 23981  |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ALBERT C. PATTERSON   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>07 03 91  |  |  |  | 3. TIME OF DEATH<br>102 AM  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>172-05-7141  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>81 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept. 28, 1909                                |  | 8. BIRTHPLACE (State or Foreign Country)<br>Alabama   |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Good Samaritan Hospital   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  |  |  | 9c. COUNTY OF DEATH<br>-----N/A-----  |  |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>-----N/A-----  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>6228 Northwood Drive  |  |   |  | 10f. ZIP CODE<br>21212  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 years<br>College (1-4 or 5+) 4 years  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Electrician   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Owens Yacht Company   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Joseph Henry Patterson   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Aurora Campbell  |  |  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Helena L. Patterson   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6228 Northwood Drive Baltimore, MD 21212   |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Moreland Memorial   |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD  |  |  |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John E. Salor</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Johnson Funeral Home Balto., MD 21204<br>8521 Loch Raven Blvd.  |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerotic Cardiovascular Disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward M. Miller</i>                                    |  | 29c. LICENSE NUMBER<br>D19423   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/3/91 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Edward M. Miller, MD 5601 Loch Raven Blvd Balto, Md 21239  |  |   |  |   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julian Davidson-Randall</i>   |  |  |  |   |  |   |  |   |  |



91 23982

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARION DELNOCE PERSONS   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 1, 1991  |  | 3. TIME OF DEATH<br>8 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>060-34-5428   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>77 YRS.  |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 21, 1913  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>6915 Kenleigh Rd.  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>6915 Kenleigh Rd.  |  |   |  | 10f. ZIP CODE<br>21212   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES            |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>if yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>4 Years  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Director,<br>Licensing of Day Care Centers |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Baltimore City   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Louis Delnoce   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lillian Stodoff   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>E. Grey Persons, Jr.   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1521 Powells Tavern Place, Herndon, Virginia 22070  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Elmwood Cemetery   |  | DATE<br>9/6  |  | 20c. LOCATION — City or Town, State<br>Norfolk, Virginia  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James F. Burnside, Jr.  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home, Inc.<br>6500 York Rd. Baltimore, Md. 21212  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <u>HSCTD</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Charles F. Donnell MD   |  |   |  | 29c. LICENSE NUMBER<br>21093   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-1-91   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Charles F. Donnell MD - 2304 Wondervan Rd - Lumbard, Md   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Rendell   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained by the funeral director, page 6 should be retained by the funeral director, and page 7 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEM:20b per FH  
G-679 9/9/91 cm

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23983

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>REMINTAL G BULLOCK ROSS</b>   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>02</b> YEAR <b>1991</b>   |  | 3. TIME OF DEATH<br><b>1148A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-56-9062</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>50</b> YRS.   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12-1-40</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>  |  | 9. COUNTY OF DEATH<br><b>BALTO. MD</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO. MD</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTO. MD</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>BALTO.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>6512 ARMSTRONG AVE</b>  |  | 10f. ZIP CODE<br><b>21215</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>NEGRO</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>   |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CLERK</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>NATIONAL SECURITY</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES GILLIAM</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BEATRICE YOUNG</b>   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>LEONARD ROSS JR</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16512 ARMSTRONG AVE BALTO MD 21215</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Auburn Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Ross</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH L. ROSS<br/>2222 W. NORTH AVE 21214</b>  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial INFARCTION</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Hypertensive Cardiovascular disease</b><br><b>Hypertension</b><br><b>Pituitary Apoplexy</b><br><b>Diabetes Mellitus</b> |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9/3/91</b>  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Shula Walker MD</b>  |  | 29c. LICENSE NUMBER<br><b>D25663</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9/3/91</b>   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  | 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Lia Davidson-Rendell</b>   |  | 33. DATE OF DEATH (Month, Day, Year)<br><b>9/3/91</b>  |  | 34. TIME OF DEATH<br><b>1148A</b>  |  |

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | 91 23984   |  |
|--|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  | REG. NO.   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>VINETTA ELIZABETH RUFF   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>AUGUST 30, 1991  |  | 3. TIME OF DEATH<br>12:05 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-14-6231   | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>78 YRS.  | 7. DATE OF BIRTH (Month, Day, Year)<br>SEPT. 4, 1912 | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>803 BERNADETTE DRIVE   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FOREST HILL   |  | 9c. COUNTY OF DEATH<br>HARFORD   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>HARFORD   |  | 10c. CITY, TOWN OR LOCATION<br>FOREST HILL   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>803 BERNADETTE DRIVE   |  | 10f. ZIP CODE<br>21050   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA College (1-4 or 5+) NA   |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME   |  | 17. FATHER'S NAME (First, Middle, Last)<br>THOMAS BELL   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>SADIE (UNKNOWN)   |  | 19a. INFORMANT'S NAME (Type/Print)<br>AUDREY E. BARRY (DGHTR)  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>803 BERNADETTE DRIVE, FOREST HILL, MD. 21050  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MEADOWRIDGE MEMORIAL PARK   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John P. Edwards</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br>SCHIMUNEK FUNERAL HOMES, INC.<br>3331 BREHMS LANE, BALTIMORE, MD 21213   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC BREAST CANCER<br>Approximate Interval Between Onset and Death 3 YR<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |
| 24. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John P. Edwards, M.D.</i>  |  | 29c. LICENSE NUMBER<br>D 31775   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>8/30/91   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JOHN P. EDWARDS, M.D. 2112 BELAIR RD<br>FALLSTON, MD 21047  |  | 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |  |  |



91 23985

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Reich Walter Lee Jr.</u> Walter Lee Reich, Jr.   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>2</u> YEAR <u>91</u>   |  | 3. TIME OF DEATH<br><u>22:40 P</u>  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>212-22-6595</u>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>66</u> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>12/01/24</u>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Maryland</u>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>St. Agnes Hospital</u>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>   |  |
| 9c. COUNTY OF DEATH<br><u>---</u>   |  |  |  | 10a. STATE<br><u>MD</u>  |  |   |  |
| 10b. COUNTY<br><u>Baltimore</u>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><u>Baltimore / Catonsville</u>  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><u>2116 OLD FREDRICK RD</u>  |  |   |  |
| 10f. ZIP CODE<br><u>21228</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><u>WW II</u>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE - American Indian, Black, White, etc.<br>Specify:<br><u>White</u>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>2</u> College (1-4 or 5+) <u>2</u>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Data Processor</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Noxell Corporation</u>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Walter Lee Reich, Sr.</u>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Mildred Hipsley</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>S. Joan Reich</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2116 Old Frederick Rd. Balto., MD 21228</u>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Lorraine Park Cemetery 9/6</u>   |  | 20c. LOCATION - City or Town, State<br><u>Woodlawn, MD</u>   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>George E. MacNabb</u>   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><u>MacNabb Funeral Home, P.A.</u>   |  | 22. ADDRESS OF FACILITY<br><u>301 Frederick Rd. Balto., MD 21228</u>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Metastasis from Prostatic Ca</u><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <u>ASCVD - COPD</u><br>b. <u>ASCVD - COPD</u><br>c. <u>ASCVD - COPD</u><br>d. <u>ASCVD - COPD</u> |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><u>9/2/91</u>   |  |
| 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>PAOLA S. AGNES</u>   |  | 29c. LICENSE NUMBER<br><u>---</u>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><u>9/1/91</u>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>TUMBINELLO PAOLA S. AGNES</u>  |  | 31. DATE FILED (Month, Day, Year)<br><u>SEP 4 1991</u>   |  | 32. REGISTRAR'S SIGNATURE<br><u>Jana Davidson-Rendell</u>   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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9-10-91; dr

item 18; film g-679;  
9-10-91; dr

91 23986

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>William H. Rehmann   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-2-1991  |  | 3. TIME OF DEATH<br>4:10 A. M.   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-16-5231   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>71 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11-20-1919                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Balto., Md.   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Good Samaritan Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |  |  | 9c. COUNTY OF DEATH<br>N/A  |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>N/A   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore City   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br>4016 Biddison Lane   |  |  |  | 10f. ZIP CODE<br>21206  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12th Grade  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Baltimore City Police  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Sergeant   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Rehmann  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Katherine Breitnother  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Shirley Jeffery Rehmann  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4016 Biddison Lane, Baltimore, Maryland 21206  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gardens of Faith Cemetery 9/6   |  | DATE<br>9/6   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland                           |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Katherine M. Murphy   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>John C. Miller, Inc.<br>6415 Belair Road, Baltimore, Maryland 21206   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>CARDIAC ARREST DUE<br>TO VENTRICULAR ARRHYTHMIA<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>CORONARY ARTERIOSCLEROSIS |  |  |  |   |  |  |  | Approximate interval between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                                |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Luis Rivera  |  | 29c. LICENSE NUMBER<br>D08344  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/4/91   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Luis Rivera, 5714 Harford Road, Baltimore, Maryland 21214   |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell   |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91-4675-510

91 23987

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |   |   |   |
|---|--|--|--|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert Searcy</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 16 1991</b>   |   | 3. TIME OF DEATH<br><b>12:53 PM</b>   |   |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>27</b> YRS. |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-30-64</b> |   | 8. BIRTHPLACE (State or Foreign Country)  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5610 Loch Raven Blvd. Apartment D</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |   | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTO</b>   |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>5610 LOCH RAVEN BLVD APT D</b>   |  |  |  | 10f. ZIP CODE<br><b>21218</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                          |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>UNEMPLOYED</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James H. Searcy</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Engle</b>  |   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robin</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>States Attorney Office</b>  |   |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MEXICAN COM</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO Co. MD</b>  |   | 20d. DATE<br><b>8-8-91</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph LeRoux</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph LeRoux F. H.</b><br><b>2202 W. NORTH AVE 21216</b>  |   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE GUNSHOT WOUNDS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |   |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |   |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input checked="" type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>08 16 1991</b>  |  | 28b. TIME OF INJURY<br><b>1243P</b>   |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |   |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Home address</b>   |  | 28e. DESCRIBE HOW INJURY OCCURRED<br><b>Subject shot</b>   |  |   |   |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Monica Muthuk</b>  |  |   |   |   |   |
| 29c. LICENSE NUMBER<br><b>O.C.M.E.</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>08 17 1991</b>   |  |   |   |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MONIMONTA ANDIKORU 111 Penn Street, Baltimore Maryland 21201</b>  |  |  |  |   |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Leticia Davidson-Randall</b>   |  |   |   |   |   |

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ANTONIOS STAVROU   |  |  |  | 2. DATE OF DEATH<br>MONTH 8 DAY 30 YEAR 91  |  | 3. TIME OF DEATH<br>9:47 A M  |   |
| 4. SOCIAL SECURITY NUMBER<br>213-52-9183   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>53 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>7-5-38   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FRANCIS SCOTT KEY HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY   |  | 9c. COUNTY OF DEATH<br>-  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>-   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>4705 Eastern Avenue  |  |  |  | 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+) -   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Baker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Proprietor - Bakery   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Stavrou  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Christina Siskos   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Christina Tsamos  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6 Avery Court, Baltimore, Maryland 21237   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Oak Lawn Cemetery   |  | DATE<br>9-3   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ann L. Lathrop</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Matthews Funeral Home<br>3021 Eastern Ave., Baltimore, Md. 21224  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>ANTHROPIC CARDIOVASCULAR DISEASE</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br><i>yes</i> |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Walter Beckell</i>   |  |  |  | 29c. LICENSE NUMBER<br>O.C.M.E.   |  | 29d. DATE SIGNED (Month, Day, Year)<br>AUGUST 31, 1991  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL M.D. 111 PENN ST. BALTIMORE, MD. 21201  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SILVANA, HELEN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>0800</b> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>302-22-0989</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07-10-1920</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                                    |   |
| 9c. COUNTY OF DEATH<br><b>N/A</b>   |  |  |  | RESIDENCE OF DECEDENT   |  |   |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Harford</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Joppa</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>586 Renee Drive, Apartment C</b>   |  |  |  | 10f. ZIP CODE<br><b>21085</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>9th Grade</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waitress</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Karson's Restaurant</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alex Mancheski</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Katherine</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anthony L. Silvana</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>586 Renee Drive, Apartment C, Joppa, Maryland 21085</b>                                     |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery 9/3</b>  |  | DATE<br><b>Baltimore, Maryland</b>  |  | 20c. LOCATION — City or Town, State   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Katherine M. Murphy</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John C. Miller, Inc.<br/>6415 Belair Road, Baltimore, Maryland 21206</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>PULMONARY / MULTIPLE METASTASES</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>C.O.P.D.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>1 yr</b><br><b>2 mos</b> |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Howard S. Freeland MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D28127</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Howard Freeland MD 5601 Loch Raven Blvd Balto Md 21239</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John C. Miller</b>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0300: 1

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Jennie V. Smith</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-2-1991</b>   |  | 3. TIME OF DEATH<br><b>3:18 P. M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-48-7935</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9-21-1906</b>                                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Balto., Md.</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>9411 Perry Hall Boulevard</b>  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>9411 Perry Hall Boulevard</b>  |  |  |  | 10f. ZIP CODE<br><b>21236</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th Grade</b><br>College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Dress Maker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self Employed</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Simone Verderami</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa Rinaldi</b>  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Janice M. Canoles</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9411 Perry Hall Boulevard, Balto., Md. 21236</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith</b>   |  | DATE<br><b>9/5</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                               |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Katherine M. Humphrey</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John C. Miller, Inc.</b><br><b>6415 Belair Road, Baltimore, Maryland 21206</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gastrointestinal bleeding / fever</b>  |  |  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |   |  |
| b. <b>Possible Bowel infarction</b>   |  |  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |   |  |
| c. <b>Atherosclerosis</b>   |  |  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |   |  |
| d.  |  |  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>sq CVA's</b>   |  |  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ann Morrill</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D34931</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/3/91</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Ann C. Morrill, 9660 Belair Road, Baltimore, Maryland 21236</b>   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 23991

|  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET ANN SLOAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> - DAY <b>01</b> - YEAR <b>91</b>  |  |   |  | 3. TIME OF DEATH<br><b>1:45P</b> M   |  |  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>201-16-8974</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>00</b> DAYS <b>00</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>00</b> MIN. <b>00</b>                                   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>04-17-1922</b>                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>PA</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>TOWSON</b>  |  |   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>106-D CROSS KEYS ROAD</b>   |  |  |  |   |  | 10f. ZIP CODE<br><b>21210</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Executive Secretary</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Credit Company</b>                              |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert William Sloan Sr.</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marion Moffet Weir</b>  |  |  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert W. Sloan Jr.</b>   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>106D Cross Keys Road Baltimore, Maryland 21210</b>  |  |  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenmount Cemetery</b>   |  |   |  | DATE<br><b>9-4</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>                        |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Dennis Stephen Kenakis</i><br><b>Dennis Stephen Kenakis M00640</b>   |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home</b><br><b>6500 York Road Baltimore, Maryland 21212</b>   |  |  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMATOSIS</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>CARCINOMA OF LUNGS</b><br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. Breitenacker MD</i><br><b>R. BREITENECKER</b>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D-875</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/2/91</b>                                 |  |  |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. BREITENECKER</b>  |  |  |  |   |  |   |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |  |  |  |  |   |  |   |  |

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Allen Tomlin</u>  |  |   |  | 2. DATE OF DEATH<br>MONTH <u>08</u> DAY <u>30</u> YEAR <u>91</u>  |  | 3. TIME OF DEATH<br><u>5:20A</u> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>217-01-2547</u>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br><u>81</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>07 20 10</u>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Mercy Hospital</u>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Balto.</u>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><u>Md.</u>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><u>Balto.</u>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><u>3308 Eilerslie Ave.</u>   |  |   |  | 10f. ZIP CODE<br><u>21218</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>Black</u>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (8-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Retired</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Linwood Tomlin</u>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Virginia</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Mrs. Sylvia Hill</u>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>3308 Eilerslie Ave. Balto., Md. 21218</u>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Western Star Cem.</u>   |  | DATE  |  | 20c. LOCATION — City or Town, State<br><u>Balto., Co. Md.</u>                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Joseph L. Russ</u> (R.D.A.)  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Joseph L. Russ F.H.</u><br><u>2222 W. North Ave. 21216</u>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Urosepsis</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <u>Gastrointestinal Bleeding</u><br><u>Lung Cancer</u><br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Chronic Obstructive Pulmonary Disease</u>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Heather P. Prewett M.D.</u>   |  | 29c. LICENSE NUMBER<br><u>Pending</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br>▶  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Heather Prewett, M.D. Mercy Hospital 301 St. Paul Pl. Baltimore, MD 21202</u>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 4 1991</u>   |  | 32. REGISTRAR'S SIGNATURE<br><u>Johia Davidson-Randell</u>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PEDRO M. THOMPSON, Sr.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>08</b> DAY <b>31</b> YEAR <b>1991</b>  |  | 3. TIME OF DEATH<br><b>5:53 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-36-8938</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>02/07/39</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST AGNES HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>---</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>---</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>178 S. Collins Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21229</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>9th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cab Driver</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Cab Compnay</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John B. Thompson</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sarah Adella Blackwell</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy L. Taylor</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>178 S. Collins Ave. Baltimore, MD 21229</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 9/3</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>George E. MacNabb</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Md., Inc.<br/>299 Frederick Rd. Balto., MD 21228</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Gastro-intestinal Hemorrhage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Ruptured Esophageal Varices</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Cirrhosis of Liver</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Chronic Alcoholism</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input checked="" type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                |  |
|  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dennis J. Chute M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09 01 1991</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dennis J. Chute, M.D. 111 PENN STREET BALTIMORE, MARYLAND 21201</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Lelia Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dorothy R. Thomas</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> - DAY <b>2</b> - YEAR <b>91</b>  |  | 3. TIME OF DEATH<br><b>0045</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-52-7226</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-29-31</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>N.C.</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Baltimore County General Hosp</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Randalls town</b>   |  |
| 9c. COUNTY OF DEATH   |  |   |  | RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>4000 Chatham Rd</b>  |  |   |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cook</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Balto City Schools</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ethel Johnson</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Luther Thomas</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4000 Chatham Rd Balto, Md 21215</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place)<br><b>Landon Park Cem 9-19-91 Balto, Md</b>  |  | 20c. DATE   |  | 20d. LOCATION — City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James A. Thompson Jr</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. West 4300 Wabash Ave</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-respiratory failure, Dehydration</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>Cardio-respiratory failure, Dehydration</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Cancer of esophagus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>1 hr.</b><br><b>5 mths</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Bongana P. Thuder</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>019823</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/2/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>5356 Reintertan Rd Balto, 21215</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Box 100

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | CERTIFICATE OF DEATH  |  |   |  | REG. NO. |  |  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|----------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>VINA M. TRUE   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>08 31 91  |  |  |  | 3. TIME OF DEATH<br>2:55 P.M.   |  |   |  |          |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>137-28-1564   |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (in yrs. last birthday)<br>70 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>8/3/21   |  | 8. BIRTHPLACE (State or Foreign Country)<br>TENN.   |  |          |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Stella Maris Hospice   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson   |  |  |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |   |  |          |  |  |  |
| 10a. STATE<br>MD.  |  |  |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Essex   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |          |  |  |  |
| 10e. STREET AND NUMBER<br>1508 Barkley Ave.  |  |  |  | 10f. ZIP CODE<br>21221  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |          |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE—American Indian, Black, White, etc.<br>Specify:<br>White                    |  |   |  |   |  |          |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Food Processor   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |   |  |   |  |          |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Hobert Rutledge   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Alma Nolen   |  |  |  |   |  |   |  |          |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Wayne Rutledge   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>19H. Hogarth Circle Cockeysville Md. 21030   |  |  |  |   |  |   |  |          |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holly Hill Cemetery 9/4/91  |  | 20c. LOCATION—City or Town, State<br>Baltimore Md.  |  |  |  |   |  |   |  |          |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Connelly Funeral Home   |  | 22. NAME AND ADDRESS OF FACILITY<br>Connelly Funeral Home 300 Mace Ave. 21221  |  |   |  |  |  |   |  |   |  |          |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heavy failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC LUNG CANCER<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |          |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |          |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |  |   |  |  |  |   |  |   |  |          |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |          |  |  |  |
| 28a. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |   |  |          |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |   |  |          |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Carla S. Alexander M.D.   |  |  |  | 29c. LICENSE NUMBER<br>D 27087  |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/31/91                                       |  |   |  |   |  |          |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Carla S. Alexander, M.D.—Stella Maris Hospice—Dulaney Valley Rd.—Towson 21204   |  |  |  |   |  |  |  |   |  |   |  |          |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |  |  |   |  |   |  |          |  |  |  |

PC 111



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

91 23996

1. FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |                     |   |  |   |  |
|--|--|--|--|---|---------------------|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN E. VANDERMOSTEN</b>  |  |  |  |   |                     | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>27</b> YEAR <b>91</b>                             |  | 3. TIME OF DEATH<br><b>1140 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>068 09 0728</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |                     | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 25, 1912</b>                              |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>N. Y.</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  |  |  |   |                     | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                     |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| 10a. STATE<br><b>N. Y.</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Oceanside</b>   |                     |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2854 Beverly Road</b>   |  |  |  |   |                     | 10f. ZIP CODE<br><b>11572</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                     |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner</b>   |                     |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Mfg. Paints</b>                       |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Renee Vandermosten</b>   |  |  |  |   |                     | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jenny Ecky</b>                      |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. John E. Vandermosten, Jr.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>114 Dickerson Road Augusta, N. J. 07822</b>   |                     |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Cemetery</b>   |  |   | DATE<br><b>8/31</b> |   | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>               |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>C. Sherman Denny, Jr.</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MITCHELL-WIEDEFELD HOME, INC.<br/>6500 York Road Baltimore, Md. 21212</b>  |                     |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |                     |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. RESPIRATORY FAILURE</b>  |  |  |  |   |                     |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |                     |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. ACUTE RENAL FAILURE</b>   |  |  |  |   |                     |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |                     |   |  |   |  |
| <b>c. OBSTRUCTIVE LIVER DZ</b>   |  |  |  |   |                     |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |                     |   |  |   |  |
| <b>d. POSSIBLE METASTATIC COLON CANCER</b>   |  |  |  |   |                     |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |                     |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |                     |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |                     |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                     |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |                     | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                     |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |                     |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J Wat an abe, M.D.</i>   |  |  |  |   |                     | 29c. LICENSE NUMBER<br><b>J8166</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>AUG 27, 1991</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JILL WATANABE Tower 600 N WOLFE ST. BALT, MD 21205</b>   |  |  |  |   |                     |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 1991</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |                     |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25.1.1.1



91 23997

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><i>Catherine Woods</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>8</i> DAY <i>28</i> YEAR <i>91</i>  |  | 3. TIME OF DEATH<br><i>6:50 PM</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>216126964</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>70</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>3-26-21</i>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>LIBERTY MED CEN</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>BALTIMORE</i>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>BALTIMORE</i>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>1727 RUXTON AVE</i>   |  |  |  | 10f. ZIP CODE<br><i>21214</i>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>NEGRO</i>                      |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>HOMEMAKER</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>THOMAS WILLIAMS</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>JOSEPHINE SWEET</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>FRANCINE P. WHITE</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3407 JOHANN DR BALTO MD 21207</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>FRANCIS MARY PARK BALTO MD</i>                         |  | 20c. LOCATION — City or Town, State<br><i>BALTO MD</i>   |  | 20d. DATE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph L. Rios</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>JOSEPH L. RIOS FID<br/>2222 W. NORTH AVE 21216</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary arrest</i>  |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |  |
| b. <i>Sepsis intraabdominal abscess</i> 8/21/91  |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| c. <i>Acute diverticulitis, pneumonia</i> 8/10/91  |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| d.   |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>D. PARKES</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D34730</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>8/28/91</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>D. PARKES 2600 Liberty Htg</i>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 4 1991</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Rendell</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general  
description of the project and its objectives.  
2. The second part is a detailed description of the  
methodology used in the study.  
3. The third part is a description of the results  
of the study.  
4. The fourth part is a discussion of the results  
and their implications.  
5. The fifth part is a conclusion and a list of  
references.

91 23998

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT L. WHITFIELD</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>AUGUST 30, 1991</b>  |  | 3. TIME OF DEATH<br><b>5:55 a.m. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-40-3391</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>49 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-9-42</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>   |  |
| 10a. STATE<br><b>MD</b>   |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>1004 E. FEDERAL STREET</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21202</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (9-12)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BALTO. CITY PUBLIC SCHOOL</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CECIL A. WHITFIELD</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AMANDA JONES WILLIAMS</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>EDITH WILLIAMS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2610 HARFORD ROAD/BALTIMORE, MD 21218</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>VOSHALL MEMORIAL GARDENS</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Glading Wane</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C.MARCH F.H./1101 E. NORTH AVENUE</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Candidemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Dilated Cardiomyopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><b>5 years</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Eliot Heiter MD</i>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ELIOT HEITER Tower 110 Johns Hopkins Hospital Baltimore</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6275 12

91 23999

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DARLENE WILLIAMS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>31</b> YEAR <b>91</b>   |  | 3. TIME OF DEATH<br><b>1:50 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-84-0111</b>  |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>28</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-13-1962</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>2405 DRUID HILL AVENUE</b>  |  |  |  | 10f. ZIP CODE<br><b>21217</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>UNEMPLOYED</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EMMANUEL MONROE</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JOANN RAINEY</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROSETTA BARLEY</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2405 DRUID HILL AVENUE, BALTIMORE, MD. 21217</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>  |  | 20d. DATE  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Charlene Brown</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.<br/>1913 W. BALTO. ST., BALTO. MD. 21223 P.O. BOX 4433</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>UNCAL HERNIATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>INTRACRANIAL EVENT (TOXOPLASMOIS)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>1 min</b><br><b>4 months</b> |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HIV ⊕</b><br><b>MALNUTRITION</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>David K... DEPT OF MEDICINE</b>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/31/91</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>22 S GREENE ST</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>SEP 4 1991</b>   |  |   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  | 33. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21205-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the funeral permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 24000

|   |  |  |  |   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARTHA V. WAUDBY  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>AUG. 31, 1991   |  |  |  | 3. TIME OF DEATH<br>3:00 A M  |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-01-3654  |  | 5. SEX<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>MARCH 12, 1915                             |  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>MERIDIAN MULTI MEDICAL CENTER   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  |  |  | 9c. COUNTY OF DEATH<br>BALTIMORE  |  |  |  |   |  |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>---   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO           |  |  |  |   |  |
| 10e. STREET AND NUMBER<br>3616 ELMORA AVENUE  |  |  |  | 10f. ZIP CODE<br>21213  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |   |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                     |  |   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA<br>College (1-4 or 5+) NA  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>WAITRESS                        |  | 16b. KIND OF BUSINESS/INDUSTRY<br>RESTAURANT  |  |  |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOSEPH SCHMEIZL  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>CLARA MAE MORAN  |  |  |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MICHAEL WAUDBY (SON)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10113 TIPERARY ROAD, BALTIMORE, MD. 21234  |  |  |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARDENS OF FAITH CEMETERY                                     |  | DATE  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD.                                |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Eugene J. Laster</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SCHIMUNEK FUNERAL HOMES, INC.<br>3331 BREHMS LANE, BALTIMORE, MD. 21213   |  |  |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Fracture of legs 20</i><br>b. <i>Peripheral vascular disease</i><br>c. <i>20 days</i><br>d. <i>20 days</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <i>Pneumonia</i><br>b. <i>COPD</i><br>c. <i>Dementia</i><br>d. <i>S/P Fr hip ~ 9 mos ago</i><br>e. <i>S/P foot amputation</i> |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>20 days   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Pneumonia</i><br><i>COPD</i><br><i>Dementia</i><br><i>S/P Fr hip ~ 9 mos ago</i><br><i>S/P foot amputation</i>   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                        |  | 28. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)               |  |  |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Alicia Foley</i>  |  | 29c. LICENSE NUMBER<br>D30717  |  | 29d. DATE SIGNED (Month, Day, Year)<br>SEP 4 1991 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print)<br>DR. ALICIA FOLEY, UNION MEMORIAL, 201 E. UNIVERSITY PKWY, BALTO, MD.  |  |  |  |   |  |  |  | 31. DATE FILED (Month, Day, Year)<br>SEP 4 1991   |  | 32. REGISTRAR'S SIGNATURE<br><i>Jana Davidson-Randall</i>  |  |   |  |

